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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

The MLI Nursing Service
Its Discontinuance Presents a Challenge

ALTHOUGH THE WORLD about us is constantly changing, each change brings its own challenge and each time we wonder for the moment if we will be able to meet the new demands. No doubt many of us felt this way after reading the announcement of the Metropolitan Life Insurance Company's plan to discontinue its visiting nurse service by January 1953.

During the professional life of most of us—and in fact throughout the lifetime of many of us—there has always been a Metropolitan nursing service. Its beginning antedates the founding of the National Organization for Public Health Nursing by three years. We know full well that this decision by the Metropolitan's Board of Directors to terminate this program was reached only after the most careful analysis and consideration.

In the official announcement Mr. Leroy A. Lincoln, president of the company, says, "Visiting nurse associations have multiplied in number and expanded in scope [since 1909]. Local health department participation in nursing is growing, as are voluntary sickness insurance programs with nursing benefits. Medical facilities available to the general public have expanded rapidly, and new discoveries are lessening the incidence and shortening the duration of many illnesses." These are the goals we have all joined forces to achieve. Although the road ahead is still long and somewhat winding we have in 1950 arrived at higher standards of public health than ever before, and programs such as the Metropolitan's have made their contributions to such progress.

As a sound business venture, the insurance company was and is primarily concerned with improving the health of its policyholders. Because so many aspects of health are related to the family and the community the nursing service to the insured individual naturally benefited other members of the household. From a community point of view the greatest advantage of this nursing service may well be the entree to homes of millions of the insured by public health nurses who might otherwise not have ready access to those families.

Much more can be said in recognition of the services rendered. Before the Metropolitan's home nursing program bows out finally, we shall take further opportunity to review other phases of its services. Now it seems well to consider briefly what the termination of the contract with this insurance company will mean financially to VNAs. Nursing service to policyholders of the company has been decreasing. Many VNAs have faced the fact of a declining income from this source over the years and have found this an additional stimulus to go out into the community and seek other sources of income.

FIRST, IT IS obvious that the standard of living and the level of family income today are vastly different from what they were in 1909. In all communities there are families who can afford to pay for nursing service

who are not using the service. Why? Many still have a very fuzzy idea about the public health nurse—what she does, whom she serves. Continuous emphasis on public information campaigns certainly is one answer.

Second, other avenues of new income are opening. While it is true, as Mr. Lincoln says, that "many conditions previously treated at home now commonly receive attention in hospitals," there is also growing interest in home care plans. Such plans can be successful only if the community nursing agencies are brought into the program. It is economically sound that nursing care to patients transferred out of the hospital to their own homes be paid for in some way, and it should be remembered that the cost of such care is lower than the cost of caring for the patient in the hospital.

A third source of new income has scarcely been tapped—inclusion of nursing benefits in health insurance plans. The recently published "Guide for the Inclusion of Nursing Service in Medical Care Plans"* should be required reading for every public health nursing director and the members of her board.

When the early contracts were made with the Metropolitan Life Insurance Company many VNAs were still proving themselves to their communities. There had not been enough time to develop detailed business practices. The emotional appeal of public health nursing was strong, and many agencies were founded on such a basis. This has changed with the passing of years, with active, representative boards of directors, strong executives, better qualified staff, and with counsel from the NOPHN. Today no one would question the soundness of public health nursing programs, but there still is a selling job to be done.

ANY VNA SEEKING new contracts for nursing service will find it smoother going if the approach is made on a business basis. We know what our community needs are; we know what service we can give; we know what these mean to the citizens. We should know our costs also, because this is fundamental in working out any business arrangements. As we have come to know, there may be considerable variance between our *charges* and our *costs*. Fortunately the NOPHN cost analysis method is available. Through the processes described in the method any and all costs may be ascertained. If you have not already planned to do a cost study, it should be considered for this year.

The Metropolitan Life Insurance Company has set a date more than two years ahead for the termination of its contracts. While this seems generous in many ways, still it is a short time to effectuate major changes in sources of income. There are localities where the Metropolitan-employed nurse has been furnishing the only bedside nursing care to the sick in their homes. Such communities face the need for immediate development of services to replace those being withdrawn. This is their opportunity to consider communitywide public health nursing programs.

On all of these problems NOPHN will work closely with its member agencies, the board and committee members, public health nurses, official health departments of this country, and with the MLI to reach the best possible solutions. As this is written, conferences are being held to decide on first steps toward constructive action. Special conferences, perhaps a national conference of NOPHN member agencies, are especially needed now. Increasing the personnel and activities of the ANA-NOPHN Committee on Nursing in Medical Care Plans becomes imperative. More field consultation must be provided for member agencies and for communities wishing to improve or develop bedside nursing services.

In a time of challenges, this is indeed a major challenge to the communities and the public health nurses of this country. Individually the going would be very difficult. Together we will find a way to meet the issue and learn new ways of improving nursing services to communities as we do it.

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* Committee of the American Nurses' Association and the National Organization for Public Health Nursing on Nursing in Medical Care Plans. Guide for the inclusion of nursing service in medical care plans. N. Y., NOPHN, 1950.

Miss Gardner Writes About The MLI

Yes, I have heard with dismay the announcement of the Metropolitan Life Insurance Company, but it seems to me that during all these years the company has been pretty generous toward public health nursing throughout the country, and all things considered there has been singularly little friction and misunderstanding to cope with in situations where there might have been a great deal. In the early years I am sure that this was in large measure due to the existence of the NOPHN.

For the first three years, or thereabouts, in which the company paid for nursing service given by the various privately supported visiting nurse associations, there was no National Organization for Public Health Nursing and each agency struggled alone with problems presented by the new relationship. As soon as the NOPHN became strong enough to produce definite leadership for a common general policy most of the difficulties faded away. I think that if the MLI which, after all, is a business concern, not primarily a health agency or a charitable institution, finds that it is to its business interest to withdraw the nursing service, it seems to me that in giving us time for readjustment they are doing all that we can expect from them.

MARY S. GARDNER,
HONORARY PRESIDENT, NOPHN

Korea

THIS GOES to press five weeks after the start of the Korean incident. The world once again has been shadowed with tragedy. Our hope is yet that cool heads and sage leaders will win out in the council halls and that the crisis will not flame into a formal war. National and personal security have been threatened and we react in a variety of ways. Some of us will find ourselves called or impelled to volunteer for military services. Some of us will have to meet the challenges of these dramatic times by remaining on our jobs strengthening community services. Civil defense again becomes a vital part of the national picture. It cannot be built up overnight, any more than our men in Korea could be armed overnight. It will take time to study existing plans, broaden these in the light of the new inventions for total war, and prepare personnel. There is a job for everyone, especially for the nurse. But each one must learn her job, her place, in the overall plan.

The program of the National Security Resources Board is described on page 522. The NOPHN will work closely with the other national nursing organizations and with NSRB in planning and coordinating programs for civil defense. The master plans undoubtedly will come from Washington and from our state capitals, but the job will be carried out in the grassroots. Keep informed, be available. Do your part, whatever it may be. Our best defense is preparedness; our goal, whatever the path, international understanding.

CITIZEN PARTICIPATION IN PUBLIC HEALTH NURSING

The following four papers are based on the material presented at a program meeting of the NOPHN *Board and Committee Members Section in San Francisco during the Biennial Nursing Convention.*

1. Opportunities for Citizen Participation

DOROTHY B. NYSWANDER, Ph.D.

THERE ARE several questions we who are not nurses, we lay citizens, need to think through if we are to be clear in our own minds as to what participation in community work associated with public health nursing really means.

Why participate? Why should we make the effort to join with others in some social endeavor which is bigger than ourselves? Why should we neglect the garden or the family mending or give a few extra evening hours or weekends after working in an office all day to meet with a committee or to give services as volunteers? The usual answers to this question are: that every citizen needs to share in the responsibilities of community life; that living in a democracy demands continual checks and balances be maintained by each of us as citizens; that basically the democratic ethic assumes that what we do in a community now and in the future should be the result of shared planning and group decisions. These are good reasons. They are reasons which have become a part of what we call our "social conscience," our "social self." They are mature reasons.

But there is still another reason, one that only in recent months has emerged from research work in group therapy and social psychology. This reason for participating in group work with our neighbors and other citizens is because we now know that working with others in committees and organizations is a kind of insurance for good mental health in adult life. We know now that through group activity we can learn to change our ideas and develop new ways of behaving and new interests in life. It has been found that this interchange of ideas and exploration of new areas of thought and action which take place when we work with others are vitalizing forces. Personal security and satisfactions in living are developed and reinforced. Group work appears to be an antidote to stagnation and futility. Knowing this, how can we fail to seek group work opportunities for ourselves? How can we be so neglectful as to deny such opportunities to others? We pose a second question.

What prevents greater participation? What prevents many of us and our neighbors from taking an active part in civic affairs? There are many reasons. Among them, I think these are important. First of all, until recently we

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did not recognize the therapeutic values of group work. We did not realize that our own growth in achieving emotional maturity is facilitated by learning how to work comfortably with others. We did not sense that our personal needs for security and independence can be met best when we "find" ourselves in working with other adults.

In the second place, the democratic ethic, the conviction that we are responsible for the community in which we live, has not been developed to the point where mouthing the words of democracy has carried over into sharing the work *in* a democracy. Many people are content to let others carry the burden for them. They do not have the sense of responsibility that demands personal sacrifice.

A third reason is found in the thinking of professional people themselves. It does not occur to many of them that they have an obligation to provide for citizen participation, for the personal growth and satisfactions of the people whom they serve. They prefer to do their work alone; they do not want to be "bothered" with advisory committees. And there are those administrators and supervisors who are afraid of citizen participation. They say that: "Lay committees will get out of control." . . . "We don't want pressure groups." . . . "Committees take up too much of the time of the nursing staff." What these administrators betray through such statements is their ignorance of the values of citizen support; their own insecurities in working democratically with others; and their utter oblivion to the responsibility for providing opportunities to citizens to participate in the life of their own community.

We will not increase the numbers of lay people taking part in community activities until on the one hand citizens are convinced that important values will accrue to them personally and to the community through such participation, and on the other hand, administrators and supervisors learn to feel secure with lay committees and recognize their obligation to give lay citizens a chance to work side by side with the professional workers. We come now to our third question.

What opportunities exist for lay participation? We can now direct ourselves to finding the answers to this question in the specific field of public health nursing. Surely wherever needs exist in any of the many public health nursing programs that lay persons can fill as well as or better than the professionally trained nurse, there is an opportunity for citizens to do a job. And wherever a group of people in a community undertake the task of assessing their health problems and working toward their solution—again lay citizens, and particularly those who are fired by the desire to promote adequate public health nursing services, are needed as working members. Let us be specific.

Lay citizens are needed as general members of the local, state, and national organizations of public health nursing. As citizens we are consumers of their nursing services. As citizens we have constructive ideas to contribute to their planning since we look at their work with a different, but friendly, eye. As a matter of fact, they need us to help them interpret their service to our communities. Professional people are notoriously poor when it comes to selling the values of their own professional work.

We are needed, too, as board members of the associations. There are many working committees on boards that might take on new life if suggestions from some lay members were at hand.

Why is it that every public health nursing service has not developed an advisory committee or committees? Those doing so have a vigorous public support for their work that appears lacking in nursing services where no lay advisory committee has been developed. Each of the nursing services needs many kinds of help at different times. For example, there are a multitude of tasks a lay advisory committee to the school nursing service can give. New policies need to be interpreted to the PTA and other civic organizations; publicity on special programs is desirable; exhibits and posters for conferences, workshops, and conventions are willingly prepared by the talented lay members; three or four radio programs a year can be the responsibility of another committee.

A committee of lay members is able to

plan a long-range program for bringing in five or six different citizens each month to visit the public health nursing agency and giving them personal orientation in the work and the problems of the agency. In an organized program of this type, within a year's time approximately 100 influential men and women will obtain first-hand information about the objectives of public health nursing and how the nurses go about reaching these objectives.

Committees, too, are needed to facilitate the work of every clinic wherever it may be because the health services rendered belong to and are a part of the neighborhood where they are given. I refer here to the volunteers who aid in testing vision of school children, obtain height and weight records, act as receptionists in the school health room. Volunteer committees do a multitude of important tasks in the well child conference. Their work varies from providing flowers, books, and toys to make the waiting room attractive, to helping the nurses in their routine conference work.

There is growing sentiment in favor of developing neighborhood health committees and community health councils. More and more we are appreciating the fact that a health committee and council have vigor and life in proportion to the number of lay citizens who make up their membership. Professional members are needed as consultants, but they do not have time to work on the tasks which we lay citizens believe are important. It is our job not theirs to study our problems, coordinate our resources, and plan new programs to meet our needs. These are the functions of health councils, and we who are interested in public health nursing must make ourselves heard in the councils where planning for the future is taking place. A final question arises as we think about ourselves as community participants.

Which tasks will bring greatest satisfaction? Tasks which appeal to one person will not appeal to another. As adults, our emotional and social needs differ perhaps more widely than similar needs of children. There are satisfactions we want, however, which are common to all of us in whatever task we undertake. Therefore, it behooves those planning for our participation as citizens to recognize our needs.

We like tasks which bring us a sense of doing something important.

We want to understand how our task or contribution fits into a larger picture of activity.

We want to participate on the same level as anyone else on the committee. We do not want to be "token" representatives of an organization. We do not get satisfaction from being "rubber stamps" for ideas formulated by the professional workers.

We like tasks which we can do well. We want orientation and instruction to this end. We want to read and study in the field so that we get a feeling of personal growth. We do not like "dead-end" jobs.

We like tasks with responsibility. We know we can take it.

We like work which has the flavor of a new venture. We want our work to be evaluated and to change on the basis of evaluation.

In fact we derive satisfactions out of the same kind of emotional climate in a job or committee situation that the professional nurse wants for herself.

Summary: In this brief presentation I have tried to point out that:

1. We as lay citizens need to participate in work with others because it is important for our emotional and social maturity and because only through participation in community life can democracy become a living fact.

2. Often we fail to participate because of our own ignorance and apathy. Often, however, community leaders take no steps to plan ways in which we can join them in their work.

3. The opportunities for participation are varied and numerous. Wherever public health nursing exists there is need for our help. We are needed in the councils of community planning, in advisory committees, in service committees, and in committees whose task it is to interpret the work of public health nursing to every ear that will listen and every eye that will read.

4. Citizens find their satisfactions in tasks in the same ways as do professional workers. We have common needs for recognition, responsibility, and growth.

2. A Program for Volunteers

ELEANOR S. MOSHER

"CITIZEN PARTICIPATION" is a meaningful expression for specialists in social science, but the citizens don't like it. They say, "Oh, so now we are citizen participants. Next thing, we'll be CP's." Maybe they are reminded of the impersonal fusion of individuals we experienced during the last war. Could we say instead, "Citizens are participants?" Then they'd be CAP's which sounds a little better.

The way the terms "private" and "public" are being used in public health nursing discussions indicates that we think of the relationship of the two as a partnership and not in opposition to each other. If one challenges the other so much the better. Since community health is our goal, whether it be a "right" or a "responsibility," there is a big job for all of us in achieving it. I want to make a plea for many more citizens to take an active part in the effort.

"Volunteer" is the word I like to use. In the Visiting Nurse Service of New York we think of volunteers as being that large corps of women who give of their own time, who impose their own obligations, who work with the professional staff without coercion and without pay to promote the effective and productive functioning of the agency's programs, for the cause of human progress. Note, I say work *with*, not work *for*, the professional staff. This is the keynote of the philosophy underlying the volunteer program in our organization.

Volunteers have always been needed. When Lillian Wald, a truly audacious American, founded the Henry Street Visiting Nurse Service she must have sensed that with the backing of public sentiment nothing could fail. Her need in 1893 to have the community understand the concept of public health nursing so that people would cooperate and support the program, was the same as it is for us in 1950.

Today the VNSNY knows creativeness depends not only on the scientific performance of its professional staff but also on a large number of citizens. These citizens are trained to understand and cooperate with the service, trained to interpret the administration, the work of the nurses, the different types of nursing service, the staff educational program; they are trained to understand how the service cooperates with public and private agencies, and the place of the VNSNY in the total health program of New York City. About 525 volunteers armed with this kind of training channel accurate information to the public. Patients do some of this too, but that's not enough. We use the press, radio, and television, but we always come back to the most effective means of communication—word of mouth.

And who can do this better than women? As the new drugs came into use, women volunteers learned why the case load changed and what this meant to the agency administration and to the patient. Our members are very much aware that rehabilitation is becoming a new facet in nursing of the aged and they are learning rather dramatically how life is being extended and the social implications of this not only for their communities but also for their families and themselves. This kind of education goes on constantly in group meetings with the professional staff and with representatives of other agencies. And through the lay members, information about the service goes out along many avenues;

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these members are the transmission line between the professional group and the public.

The Center Committee

How we recruit volunteers, how they function, and how we hold them, are questions which are asked.

We have fourteen district offices, each with its supervisor, assistant supervisor, and nurses. Each has at least one organized lay group of volunteers called a center committee or an auxiliary. In Manhattan and the Bronx there are nine center committees. In Queens, that fast growing borough of vast, sprawling area, we have three nursing centers. Here, however, we have two center committees and seven auxiliaries, representing nine distinct communities which would ordinarily be called towns.

In no way whatsoever are these committees and auxiliaries to be thought of as boards of directors. They have nothing to do with the management of the service nor with the making of its policies. You may wish to think of them as service volunteers to distinguish them from board members.

Let me tell you how we are organizing our newest group and, may I say, it's never done twice the same way. One of our oldest groups in years of service, matrons living in the swank Park Avenue area, serving as a center committee for the Lower East Side, was beginning to grow tired. The members knew they needed new blood but did nothing about it. The group was prodded by members of the council: "You know, the VNSNY began its work on the Lower East Side. This puts you as Center Committee for this area in a position to experiment, to venture something new, to carry on the creative spirit of the service." Now it happens that two large housing projects, known as Peter Cooper Village and Stuyvesant Town, are located near our Lower East Side office. The committee was asked, "Why not get some of the young matrons from these projects together and start an auxiliary?" So it was that eight young women (friends of friends) were invited to a tea at the home of a committee member. They were told of the VNSNY, the work the nurses were doing in the projects, and how they themselves could use the service. One of the young women, we learned, was attending the class for expectant mothers held at the district office.

The young women met next at the Lower East Side office. The supervisor did an excellent job of describing the variety of nursing service being given in that health area and showing the young women around the office. Four signed up for volunteer jobs then and there. Then the original group said, "Why not invite them to become members of our committee?" The young women themselves will make their own decision as to whether they wish to be an independent group or belong to the established center committee. Now, plans are in the making for a big membership tea to be held at headquarters.

At this point I can predict what probably will happen. The group will balloon up to about fifty. Next winter some will drop out, but a year from now we will have twenty to twenty-five active, interested, enthusiastic volunteers who will stay with us. It takes about two years to organize an active working committee. If an emergency existed it could be done overnight. What has happened to the women in the established group? They have been revived, if you please, they are having the best meetings they have had in years. They just gave one of the most ambitious benefits ever held for the service, managed entirely by themselves. One husband asked, "What kind of a shot has the VNSNY given my wife? She's a new woman."

It is the variety in the groups that gives color and life to the whole volunteer program. They differ in age, religion, race, economic status, and educational background. In one group we have a cross section of about all the differences, young women and older ones, white and Negro, Catholics, Jews, and Protestants, with perhaps the economic status being the common denominator. One center committee situated near a large university is made up of faculty wives. Here we have good old American individualism at its best, and, without fear of penalty I might add, it is one of the toughest groups to handle.

Each group plans its own work for the year,

its monthly programs, the kinds of volunteer work the members wish to do, their methods of fund raising, their relationships with the professional staff. We want them to preserve their individuality. My only concern is to keep them within the policies of VNSNY.

Director of Volunteer Activities

As the director of volunteer activities, I am a member of the administrative staff and at the weekly staff meetings I learn the principles of business administration and acquire an understanding of the profession of public health nursing. At the monthly meetings of the supervisors I gain an understanding of how the administrative policies of the organization are applied in practice. At the meetings of the Staff Association I get the staff nurse's viewpoint on her job, her problems, and her satisfactions. I am always impressed with the way policies develop from both directions, that is, from the staff to the executives and from the executives to the staff.

I also do my share in covering the conventions, conferences, institutes, and seminars held in the city. From these I get an insight into trends in the entire field and always a critical evaluation of my own performance in a public health nursing service. In dealing with people there is so very much to learn. Active participation in all of these group discussions and meetings helps me to interpret our service to the lay members.

I still think of myself as a volunteer and, as such, I have a deep feeling that laymen must have active roles in voluntary institutions and agencies concerned with community welfare because voluntary agencies are a part of the American way of life. It is this conviction which affects my relationship with the professional personnel. Sometimes I find my reactions are pretty naive. It's learning the hard way, but it's good discipline. If the specialist has not been taught at school or does not have something within her enabling her to accept laymen as a factor in her professional performance, she will think of a volunteer as a nuisance, someone to be put up with, instead of as an intelligent contributor, a necessary member of her team if it is to work for human betterment.

Center Committee Council

The chairmen of all center committees and auxiliaries plus the chairmen of the special committees, such as the committee on fund raising activities, make up the Center Committee Council. The council meets three times a year, twice as a closed planning body and once in an open annual meeting. This group elects its own chairman who may or may not be a member of the council. She, by virtue of her office, becomes a member of the VNSNY board of directors, the representative of the lay membership.

The council meetings are never the same. We have tried various ways of not so much solving problems as facing them together. We have had: one-day workshops, panel discussions, round table discussions, role playing, straight reporting, directed discussions, free discussion with summarizing. After every session those in charge of the meeting gather in my office for an evaluation session and they ask each other: How did this meeting go? If it was good, what made it good? Where were the weak spots? Was the method good? Did it get everyone to participate? Who needs help and how best can we give it and still have her think it her own idea or that of her group? After it is all over I silently pray that action will take place in some of the nineteen committees.

The council has in its membership some of our most promising leaders. Each center chairman has been elected by her own group. The special committee chairmen have been appointed for their special abilities and talents. They serve as chairmen of the Speaker's Bureau, the Bargain Box and Thrift Shops (which bring in incomes of about $12,000), assist nurses in mothers' classes, and cooperate with the publicity department. These are the volunteer activities which give opportunity for the development of leadership, and these leaders are the ones likely to be appointed to the standing committees of the board of directors, such as field practice, education, personnel, and publicity. Seven are at present serving on these committees. One is the secretary of the board of directors and chairman of the field practice committee, and one is now the paid director of publicity.

Why They Volunteer

How do we hold these volunteers? Perhaps a look at their motives, always an individual matter, may give a clue. But first let me describe them. In my own language they are grand, wonderful persons. To be technical, they have drive and energy, they are hard-working, they cooperate well with other people, with the professional staff and with people outside of their own group. They are flexible and good-humored, intelligent and warm. Because they have these qualities, I think they volunteer in our organization for the following reasons:

1. Our volunteers are interested in health. They approve of the work done by VNSNY and feel it is an organization worth working for.

2. Serving with VNSNY satisfies a wish to assume citizenship responsibility. The average person, man or woman, finds it dreadfully difficult to take an active part in civic affairs in the metropolitan community.

3. Some need an outside interest.

4. Some have friends serving as volunteers or mothers or aunts who have worked for VNSNY before them.

5. Some do it for prestige—it is the thing to do. Prestige is a powerful drive in any culture.

6. Some seek escape from frustration. Of these, the troubled ones tend to look in and slip out. The ones who stick with the work for its therapeutic value always make a contribution to the service.

7. And lastly (perhaps it should be first) volunteer service is a striving for happiness in the knowledge that one can't live for oneself alone.

When outsiders, educators, personnel directors in industry, representatives of government and private agencies, writers, and psychiatrists, hear about our volunteer program, they come for conferences to learn how we work with citizens. They want to know what makes us tick.

Evaluating the Program

We find certain questions helpful guides for ourselves and our visitors in evaluating our program. What do you think about these points?

1. Are we using good technics for committee organization?

2. Are we establishing good human relationships?

3. Are our group processes effective?

4. Are we working together as a harmonious whole, in other words, applying democratic practices?

5. Is the program flexible enough to permit growth and to develop leadership?

6. Are we in a small measure solving the modern woman's dilemma? How are we doing in building deminine self-respect?

This much I do know. With the leadership at the top of Marian G. Randall, who has made this volunteer program possible without blueprinting it, the VNSNY is spreading the base for citizen participation.

De Tocqueville, that eminent French journalist and political theorist, said on his visit to this country 115 years ago, "The health of democracy is to be measured according to the quality of functions performed by volunteers." Edith Wensley says in her new book,[1] "Winning the understanding and support of volunteers is worth every ounce of effort. They are after all the most priceless possession which your agency can have." I should like to add that it might be well to keep in mind the refrain from the popular song from "South Pacific": "Once you have found her never let her go."

[1] Wensley, Edith. *Building sound public relations.* NOPHN, 1949.

3. Day to Day Activities of Board Members

GERTRUDE GRAWN

VOLUNTEER interest, board member responsibility, citizen participation—by whatever name you call it—means the same thing, and it is an increasingly useful commodity in accomplishing any social work. Dr. Nyswander has convincingly presented the why and who and what of the question, and it has occurred to me that we are woefully small in number to accomplish all that could be done. Maybe it is the mission of hardy citizens to devise some way of enlisting for "peacetime work," that is, for aid in times when bombs aren't falling, those women who do come forth in large numbers in times of crisis. We work together in war or disaster very wastefully as to time, although a great deal gets done. Then when the crisis is over we quickly forget our plans to study volunteer service from all angles and work out some fundamental principles for doing a better job next time.

It is encouraging that at the Biennial we are considering citizen participation in public health nursing. My assignment is to analyze the ordinary work of board members and to suggest a few possibilities for expansion.

Attendance sounds like a dull subject, but we all know boards which haven't a very good score in that respect. Board members who can't attend meetings had better resign, and machinery should exist for accomplishing this. Once an individual is on a board and ready for action, work on a committee or committees follows. I will outline a few of the basic types of activity. Financing is the board's responsibility even in these days of federated fund raising when the problem tends to become a little remote and impersonal. It is our job, however, and every board member should have a part in soliciting funds, no matter how poor he feels he is at the task.

The administering of funds is pleasanter. But do we relax and let the treasurer read the monthly statement while our minds are on tonight's dinner or suits we forgot to leave at the cleaners? We don't. We listen and, grabbing a figure here and there, we hasten to ask intelligent questions as soon as she stops reading. We study the yearly budget. Because of our position on the finance committee we may even serve on the budget committee of the community chest and thereby learn a great deal about overall budgeting.

Next in importance is the nominating committee, which should meet once a month. The members should represent the various elements on the board and should seek for the ballot people best suited to further the work of this particular board. Too often a committee meets three days before election and chooses someone's best friend or niece with little regard for her interests or other qualifications. Board members should be representative of different religions, talents, economic groups, professions, ages, et cetera.

THE WORK OF THE agency can be explained when the new member is invited to join the board. He should be given some idea of the responsibility he is assuming also. After he joins considerable time may well be invested in educating the newcomer about the history, objectives, and routine of the work.

Mrs. Grawn is a former president of the Visiting Nurse Association of Detroit and a former member of the NOPHN *Board of Directors.*

This can be done by a board education committee working with each individual or by brief programs planned to achieve the desired end and given at each board meeting. It is desirable to plan institutes at intervals to train and educate the young board member and refresh the forgetful older one.

A personnel committee should be a busy one, studying salaries, hours, vacations, insurance, as well as broader aspects of the subject. Does the area offer good opportunities for nurses' education or do most of the best applicants come from a distance? What are the relations between the agency staff and others that lead to cooperation, efficient community service? This committee will need to consult manuals and all the available resources to know how the standards of its agency compare with those of others in the country.

There may or may not be a committee on public relations. If it is a formal body it should represent a cross section of the community. Its concern is the relations between the agency and the rest of the community—other agencies, groups of people, governmental bodies, for example, and it should scrutinize all publicity to be sure that good relations are being built. However, whether the agency is large enough to have such a committee or not, the board member is working on public relations all the time for better or worse and should be conscious of this fact. Every word we say may add to or detract from our agency's effectiveness in the area. Our biggest contribution is often in interpreting the agency and winning friends for it. To interpret requires an understanding of the work, the objectives, the history of the agency, and the significance of relationships with other groups. It requires preparation and constant awareness of shifts in activities.

VOLUNTEER COMMITTEES have several purposes. The more important one to the agency is that of bringing people into close contact with the staff and the work being done and thereby acquainting them with the agency as no other method can. The committee must plan different kinds of work to keep the volunteers interested. The activities must be useful and a real contribution to the agency. If they aren't the volunteer soon discovers it and is lost to the agency. The volunteer program is a medium for spreading understanding of the agency's program in a wide field. Probably it is the soundest method of developing the tender plant called citizen participation. Too few people grasp the idea that this isn't a casual relationship but one that needs attention. Wise supervision is needed and also the attitude that all are working jointly with a common responsibility for the whole job.

Some day this great potential, this scarcely tapped reservoir of volunteer help, will be used far more effectively than now. Who can forget those hordes of citizens who during the war were so pathetically eager to help in any way as volunteers to right the terrible wrong in the world? They are still of the same mind but waiting for someone, some cause, to wake them to action.

There are many more committees possible, but committees are not enough. There is much going on in every region that has a bearing on the success of the agency. Legislative developments affecting not only nurses but all agencies in the health field can be watched by laymen and staff, and the layman can often reach and reason with the legislators more easily than a professional person. The members of the board of the VNA in Detroit as individuals are a part of the many projects carried on in that area, as of course they would be with Emilie Sargent to inspire and work with them. The practical nurse program is an example. With several VNA board members working on it, this project grew from small beginnings to its present status in the public school system of Detroit. Under the program, which is rapidly expanding, practical nurse students are given field training in the VNA as well as in hospitals and homes.

Nursing in prepayment insurance plans should be of interest to VNA boards. Laymen can do a great deal more than has been done to urge the inclusion of nursing in insurance plans. Our VNA board is tremendously interested at present in a nurses' building to house the College of Nursing of Wayne

University and all nursing groups in Detroit. It is an ambitious program, a dream, and not a new one. I mention it to show the variety of interests that engage the attention of board members and have great influence on the work normally considered their duty as board members.

A board member in a public health agency is a fortunate person. She has a rich experience. She works with the satisfying conviction that she is part of woman's prize profession, public health nursing.

4. Citizens' Advisory Committee in an Official Agency

FLORENCE UHLS

THIS IS AN ACCOUNT of the Citizens' Advisory Committee to the Bureau of Public Health Nursing in the Los Angeles County Health Department—how it was developed, how it functions, and what its functions are. Perhaps this committee is unique in that it is related to a public agency rather than to a private one.

The committee is very much alive. I have watched it grow from a handful of members to a purposeful group of twenty-six. Its accomplishments include the organization of seven district committees, the development of printed bylaws, the publication of a "Handbook on Volunteer Services," and the planning and sponsoring of annual one-day institutes for volunteers. The number of volunteers has grown in three years from 62 to 271 and the number of hours of volunteer service from 1,531 to over 5,000.

The purposes of the Citizens' Advisory Committee as stated in the bylaws are:

1. To assist in providing the best possible public health nursing service to Los Angeles County by:

   a. Assisting public health nurses in interpreting to the public information basic to its understanding of the public health nurses program.

   b. Assisting the public health nurses by representing the communities' needs and desires for public health nursing services.

2. To promote the best interests of the public health nurses by:

   a. Studying legislation which would pertain to public health nurses and bringing to the attention of as many citizens and groups as possible the conclusions of this committee.

   b. Promoting the development of community interest and support for the program so that a service adequate to the communities' needs may be maintained.

The Los Angeles County Health Department serves a population of nearly two million and its area covers 3,562.2 square miles. It has thirteen major health district health centers and twelve smaller centers. They vary in distance from seven to seventy-five miles from the central administrative office in Los Angeles. The usual problems of a heterogeneous population exist and they require careful study and thought before plans can be made and action taken.

The Committee is Organized

What prompted the establishment of the Citizens' Advisory Committee? The director of public health nursing attended the Biennial Nursing Convention in Atlantic City in 1946 where a panel discussion was held on the

Mrs. Uhls is the former chairman of the Citizens' Advisory Committee, Bureau of Public Health Nursing, Los Angeles County Health Department.

subject, Does a Health Department Need a Citizens' Committee for the Nursing Division. She returned to Los Angeles determined to secure the approval of the health officer for forming such a committee. Armed with this approval a small group of interested citizens met in April 1947 to take first steps in organizing a countywide advisory committee. During the summer several other planning meetings were held. Letters telling about the plan were sent to key people in the health center districts and to community leaders in the Los Angeles metropolitan area not served by the County Health Department.

And so, plans took shape and the Citizens' Advisory Committee came into being. The membership consists of one representative and an alternate from each of the thirteen health districts, the director of public health nursing, who serves as professional adviser, and the director of the Division of Health Education. Members-at-large from interested organizations with health committees may be invited. The officers are elected annually. The bylaws provide for standing committees and describe the duties of the officers and committee chairmen.

Problems arise and each is met by the process of group dynamics. As Montaigne said, "It is good to rub and polish brains against those of others." In simpler language, "Minds are like parachutes; they function only when they open."

Attendance at meetings, which are usually held monthly except during the summer months, requires considerable travel time for the members. A written agenda is prepared and followed; meetings begin and end promptly. A brief social period when coffee is served precedes the meeting. There is an annual luncheon at which the new officers are installed and awards are given for one hundred hours of volunteer service. These awards are sponsored by Community Chests and Councils of America and obtained through the Awards Committee of the Volunteers Bureau, Welfare Council of Metropolitan Los Angeles.

Outstanding activities of the Citizens' Advisory Committee have included a memorandum to the governor of the state relative to the shortage of hospital beds for patients with tuberculosis and to suggest releasing additional beds for these patients; appearance before the County Board of Supervisors to present the facts and recommend action to bring public health nursing salaries in the county up to parity with salaries of other agencies in the community, and the development of an active volunteer program in every health district.

During the first year the goal of the Advisory Committee was the establishment of district committees to develop and promote volunteer activities. We believe experience as a volunteer is a good training for broader participation in community programs, and we expect today's volunteer to assume broader citizen responsibility in time.

The Volunteer Program

Orientation discussions for volunteers are held in the main administrative office. The county health officer describes the organization, function, and services of the Health Department. The director of public health nursing discusses public health nursing history, preparation and qualifications of staff, responsibilities, and relationships with other public health nursing services in the community. The director of the Volunteer Bureau of the Welfare Council discusses the role of the volunteer.

The district supervising nurse is responsible for orienting the volunteer to the local district. She supplements the general background information already given with facts about the local community and the program in the volunteer's own area. This is followed by on-the-job training in the service the volunteer will perform under the supervision of the district staff. Each new member is given a package library consisting of NOPHN reprints and publications, pamphlets from Community Chests and Councils, reprints from the U. S. Children's Bureau and the Volunteer Placement Bureau of Pasadena, and copies of materials selected by the New Jersey SOPHN from the NOPHN loan folder on lay participation. The package also includes a map showing the jurisdiction of the County Health Department and a functional

organization chart. In 1949 the *Handbook on Volunteer Services* was added.

After the program had been in effect a year volunteers were organized in six health center districts; now at the end of the third year there are active programs in all the districts. Excerpts from the annual reports of the nursing director for 1946-1947 show that volunteers recruited earlier, such as Red Cross nurses aides, continued to serve. They were augmented by recruitment from the Junior League, the PTA, and in one area by the Gray Ladies. During that year 62 individuals gave a total of 1,531 hours of service, mainly in maternal and child health conferences and in immunization programs for school children.

Volunteer Activities Grow

The Advisory Committee's goal for the second year was on-the-job training and supervision. The professional personnel and the volunteers developed mutual respect and appreciation. Volunteers increased to 96, and they served 1,746 hours. A new activity for this year was assistance with the x-ray survey unit. Recruitment and training of volunteers were continued as the committee's project for 1948-1949. The jobs had broadened by this time. One district committee rendered valuable service in locating buildings for additional health conferences and, with assistance from local service clubs, undertook to renovate the buildings. This district committee also secured additional members to staff the conferences. During this year 113 volunteers in the county gave a total of 3,156 hours of service. Up to April the 1949-1950 records show 271 volunteers have contributed more than 5,000 hours of work.

At the present time the Advisory Committee is making an analysis of the work. The committee is looking forward to more volunteer participation and hopes that the volunteers themselves will do the major part in planning for the annual institute. In some districts there is need to strengthen the local committee structure and volunteer participation. This will need time, but a good beginning has been made. The recently revised bylaws are useful instruments. We believe that there are far-reaching benefits stemming from an informed citizen group working within the framework of an official health agency, and we feel repaid a thousandfold for the effort put into establishing this project.

In summary, these are points we have found fundamental to a successful program of citizen participation: (1) take time to plan for a thorough program (2) appoint a leader to activate the program (3) plan first interviews with new volunteers with care and attention (4) give the volunteer enough to do (5) make her feel the job she does is important (6) give her some tangible form of recognition.

A Practical Approach to a Salary Study

FRANKLIN B. CAFFEE

Although the community and the agency in this report are fictitious, the suggested method of collecting data for a realistic review of salaries should prove helpful to health departments and visiting nurse associations interested in doing studies of their own staff salaries.

CEDARDALE IS a suburban town of 60,000 with a long-established visiting nurse service. In the spring of 1950 the director was faced with the loss of three nurses and was unable to recruit for two vacancies. This, of course, was a serious situation in a staff of ten nurses. The vacancies had occurred when a nearby community offered to supply two of Cedardale's best prepared nurses with agency-owned cars which had been purchased with funds raised by a group of local service clubs.

Miss Jones, the VNA director, presented the problem to the board. She felt that salary increases were the answer. The board was interested and advised that a thorough study be made. Miss Jones set about to develop a convincing statistical case for raises.

She remembered glancing through a couple of articles about salaries. She located one article in the July 1949 issue of PUBLIC HEALTH NURSING[1] and a bibliography of research materials in the March 1950 issue of the *American Journal of Public Health*.[2] The PUBLIC HEALTH NURSING article gave her the idea of developing a simple statement of the economic factors in public health nursing pay in Cedardale.

Miss Jones first reconstructed the salary history of the Cedardale VNA for the past twelve years, using old payrolls and minutes of board meetings. She found that a salary chronology brought the $1,500 minimum salary of 1938 up to the minimum $2,300 salary of 1950. See Table I for the steps.

MISS JONES FOUND that the minimum salary for staff nurses had risen $800 or 53 percent in the past eleven years. Five separate salary increases had been granted. It was apparent that the agency had made a real effort to boost salaries as prices rose. Yet the facts concerning recruitment and turnover indicated that enough had not been done. The PUBLIC HEALTH NURSING article[1] discussed the two missing factors—sharply higher income taxes and the rise in incomes of other groups in the population.

Miss Jones sent for the Price [cost of living] and Wage Data of the Bureau of Labor Statistics, material referred to in the article in the APHA *Journal*.[2] She also made a trip to the regional office of the bureau in New York. The regional information special-

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ist supplied her with an armful of pamphlets and helped her to understand the overall situation about salaries. The data supplied showed that about 14,000,000 workers in manufacturing industry had had their real wages (purchasing power) increased by about 30 percent in spite of high taxes and a 67 percent rise in the cost of living.[3,4] The studies of clerical salaries in New York, Philadelphia, and other cities showed that these workers in positions requiring less preparation were getting almost as much pay as nurses.[5]

A look at the withholding tax tables on page 4 of Federal Income Tax Form 1040 for 1949 showed that the federal income tax on $2,300 was $246 for a single person with no dependents, $146 with one dependent, and $46 with two dependents. A check with the Bureau of Internal Revenue disclosed that the tax on a single person's $1,500 income in 1938 was $14. So for a single person with no dependents, the $1,486 ($1,500 – $14) net income of 1938 was now $2,054 ($2,300 – $246), an increase of only 38.2 percent in purchasing power in the face of a 67 percent rise in the Cost of Living Index.[4] Each of the five raises had been less than sufficient to compensate for the rise in prices which had occurred in the interim.

Miss Jones used the tax table to compute the gross salary that would be needed to leave net cash take home pay 67 percent above 1938-39. She found that $1,486 plus 67 percent was $2,480. For a single person with no dependents, the tax on a salary of $2,800 is $320 and leaves $2,480. It was apparent that the level of living for public health nurses in Cedardale had fallen behind that of many other groups in the community which had been enjoying unprecedented prosperity. Each year salaries had been fixed for a year ahead on the assumption that prices would rise and then decline. But it was clear in 1950 that prices had reached a permanently higher postwar level and salaries would have to be adjusted accordingly to be realistic.

FURTHER READING of the articles in PUBLIC HEALTH NURSING[1] and the APHA *Journal*[2] brought to Miss Jones' attention the question of productivity. The constantly

TABLE 1
CHRONOLOGY OF MINIMUM SALARY, 1938-1950

Year	Action	New Rate
1938	(Salary $1,500)	
1939-41	No change	
1942	10% increase	$1,650
1943	No change	
1944	10% increase and annual salary increments made automatic upon certification of satisfactory service	1,815
1945	No change	
1946	5% increase	1,900
1947	10% cost of living bonus	2,090
1948	10% increase and cost of living bonus made permanent	2,300
1949	No change	
1950	No change contemplated	

rising productivity of the American economy, when considered in connection with the 30 percent rise in real wages (*i.e.*, level of living or purchasing power) of workers in manufacturing industries during the past decade, appeared to provide a clue as to why even a full cost of living adjustment didn't seem to offer her staff nurses a satisfactory income.[3] She found that the productivity of the American economy rises at an average rate of 2 to 3 percent per year and that the rise in productivity cannot be attributed to any one group or to any factor of production. This rise in productivity provides the ever larger pool of goods and services from which flows America's ever higher standard of living.[6,7] If this factor is taken into consideration for nursing, then the annual increase of 2 percent would have added up to 22 percent in the last eleven years. Miss Jones decided to see what this addition did to her figures.

Adding 22 percent of the prewar rate of $1,500 to the adjusted net cash figure of $2,480 gave Miss Jones a figure of $2,810 net. The gross salary which leaves $2,810 net after income taxes of $390 is $3,200.* By now Miss Jones was thoroughly convinced in her own mind that this figure should be aimed for eventually although she was fully

* If the 22 percent were figured on the 1950 salary instead of the 1938 salary, the gross salary before taxes would be $3,450 and the net cash after taxes, $3,025.

aware it was not obtainable immediately. These calculations made it clear to her why there was a shortage of nurses, why the federal government paid $3,100-$3,850 for staff nurses, why other occupations with shorter training periods lured the high school graduates. Her calculations looked like Table II.

Miss Jones looked over the bibliography of the article in PUBLIC HEALTH NURSING[1] and noticed a series of studies of budgets published by the Heller Committee for Research in Social Economics of the University of California.[8] She borrowed these studies from a nearby university library. The budget figures gave her an idea how to approach her study in another way. She took the Heller Committee's budget for a single working woman and listed the significant major items at prices she thought would be adequate for nurses. Needless to say these prices for food, rent, clothing, recreation, insurance, et cetera, were higher than those listed by the Heller Committee statisticians. This is primarily due to the very modest definition of "adequacy" used in making up the budgets.

Miss Jones took a summary of the material she had collected to a meeting of the Personnel Committee of the VNA. The members were interested in reviewing carefully the facts and figures and agreed to reopen the subject at the next meeting of the board. Miss Jones was somewhat surprised to learn that the board members felt the nurses should have considerably more for rent, food, clothes, amusement, et cetera, than the "adequate" sums Miss Jones herself had arrived at in her own calculations.

THEY STUDIED the material sympathetically but soon saw the realities of the situation precluded any attempt to raise the minimum salary from $2,300 to $3,200. Further analysis of payroll, recruitment, and turnover data for the years under consideration indicated that the practically automatic annual increments provided in 1944 had probably been a key factor in enabling the agency to hold a staff together. While the entrance salary was still only $2,300, the maximum of the range was $2,900, with six annual steps of $100 each. Two staff members had been with the agency long enough to reach the top rate of $2,900. A moderate increase would very likely keep these nurses. But two others were still at the minimum rate of $2,300 and could be expected to succumb to better offers from neighboring communities. The four other nurses had received two increments ($2,500) and would quite possibly stay in Cedardale if they were given a realistic salary increase.

TABLE II. ADJUSTMENTS NECESSARY TO MAINTAIN TAKE HOME PAY AT 1938 LEVEL

1938 salary	$1,500
Income tax	14
Net cash	$1,486
Price rise 1938-1950 (67% x $1,486)	994
Net cash	$2,480
Productivity 2% per year 1938-1949 (11 x 2 x $1,500)	330
Total net cash	$2,810
Tax on an amount leaving $2,810 take home pay for a single person with no dependents	390
	$3,200

The basic problem then was to raise the minimum entrance salary enough to make recruitment possible again. Such a boost would also make it possible to end Cedardale's reputation as a training ground from which other agencies could lure experienced nurses with offers of better pay. The board considered the desirable minimum of $3,200, the desirable range of 25 percent, and the desirable annual increment scheme of 5 percent of the minimum. It was clear that a range of $3,200-$4,000 with annual increments of $160 was amply justified by economic statistics. It was decided that neither considerations of abstract economic justice nor of ideal personnel and salary administration standards could be met. After experimenting with a number of alternative proposals a plan was developed and costs computed. See Table III. The plan was based on a salary scale of $2,820-$3,300 with annual increments of $120.

TABLE III. COMPARISON OF CURRENT AND PROPOSED SALARIES

Number of Positions and Vacancies	Salaries		Additional Cost For One Year
	Current	Proposed	
2 positions	$2,900	$3,300	$ 800
4 positions	2,500	3,060	2,240
2 positions	2,300	2,820	1,040
		Total	$4,080
2 vacancies	2,300	2,820	1,040
		Total	$5,120

The cost of $5,120 would also be increased by one half increment ($60) for the two vacancies by a proposed revision in the pay plan granting the first increment after six months instead of one year. The total cost was thus to be $5,240 the first year. The pay plan was also revised to provide that at the completion of five years of satisfactory service at the maximum of the range a longevity increase of one increment would be granted. This would involve no additional outlays for several years but would give some recognition to length of service.

The board didn't have the answer to the problem of where to get the additional $5,240 needed for the first year under the new salary scales. They well realized the alternative was to raise this sum or to cut the number of staff. One immediate possibility was to use the lapsing salary funds accruing as the result of the two vacancies. The members of the board were disturbed at the prospect of a cut in service, but they knew when additional funds became available it would be easier to fill the vacancies because of the improved salaries.

Some doubt was expressed concerning the community's reaction to higher salaries for the agency. But the board felt the economic and statistical data had proved the point and they now were in position to provide, on request, economic arguments in support of their action. They felt Cedardale was a comfortable community and would, once the facts were known, willingly pay 1950 prices for 1950 services.

The price data used in this paper are of May 1950.

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Teamwork in the Home Care of the Cancer Patient

At the Biennial Nursing Convention in San Francisco the American Cancer Society in cooperation with three NOPHN *sections jointly presented a panel discussion on the topic of home care of the patient with cancer. The leader and moderator was Dr. Howard Y. McClusky, professor of educational psychology and consultant in community adult education at the University of Michigan.*

DR. McCLUSKY set the stage and kept the activity rolling by injecting questions and comments. Everyone in the audience was given a card upon which to write questions. After the panel participants made brief statements highlighting the point of view of their special interests, the audience was given time to form buzz groups of six to eight persons. One member of each group was designated the reporter and this person was asked, at the end of the buzz session lasting about eight minutes, to step to the microphone and present one question from his group. To facilitate matters lines formed behind the microphones and since it was expected that there would be overlapping of questions, answers were not attempted until a good many of the questions were asked. At the end many questions remained unanswered because of time limitations. Questions were collected and appear at the end of this report. Organizations may find discussions centered around these questions valuable for inservice education.

As there were no prepared papers a summary of the stenotypist's notes is given below. Dr. McClusky said a panel involves interaction and communication among the participants. This of course is true, but in this report no attempt has been made to indicate questions and answers. Rather, each person's contribution has been summarized.

Miss Schlotterbeck: I don't need to tell anyone in this audience the magnitude of the cancer problem. It is the second cause of death among all people in this country and among women from thirty-five to fifty-five it is the first cause. It is impossible for us to present all the phases of the efforts being made in cancer control—in the fields of research and education, both lay and professional. For the purposes of this discussion we are chiefly attempting to center it around the cancer patient himself.

If you have a problem in dealing with cancer, will you please tell us about it? And, if any one of you has solved some of these problems, will you share your experiences with us as it is only in sharing our understanding and our problems that we are going to be able increasingly to help patients with cancer.

Dr. McClusky: We are concerned here with the discovery and the care of the cancer

Panel Members

Marjorie E. Schlotterbeck, R.N., nursing consultant, American Cancer Society.

Garnett Cheney, M.D., California Division, American Cancer Society.

Caroline Keller, R.N., director of nursing service and nursing education, Memorial Center for Cancer and Allied Diseases, New York.

Rosalie I. Peterson, R.N., chief, Nursing Section, Cancer Control Branch, National Cancer Institute, USPHS.

Ella M. Thompson, R.N., president, National Association for Practical Nurse Education, New York.

Addie Thomas, director of social service, University Hospital of the Medical Center, San Francisco.

Mrs. C. H. Turner, R.N., volunteer deputy commander, California Division, American Cancer Society.

Margaret Cree, R.N., nursing consultant in school health, State Department of Public Health, California.

Mrs. Louise L. Sturgis, program coordinator, American Cancer Society.

Mr. L. J. Peterson, administrative director, State Department of Public Health, Idaho.

patient, especially with the home care of the patient. Each one has his own special contribution. We are ready to start.

Dr. Cheney: I'll go right ahead. When the patient returns home from the hospital the diagnosis has been made, a certain amount of treatment has probably been carried out, the future treatment has been outlined, and the prognosis of the case determined. Once the care is undertaken at home, it is of the utmost importance that the person who is caring for the patient in the home on a part-time or full-time basis be thoroughly familiar with the diagnosis, the doctor's plans for the patient, and the details of the patient's care. In other words these two must work as a team. At times others enter the team also.

These patients may be classified in two categories on the basis of their disease. In the first is the patient who goes home from the hospital to recover. This patient may require follow-up care at home, but presumably if all goes well he will take up his life in his family and community again. The other group is composed of those who will not recover. These patients have to be taken care of for indefinite periods of time at home and require energetic, careful, and supervised teamwork.

Patients may be classified on another basis: those who know what their disease is and those who are not told. Personally, I believe in most cases the patient should be familiar with his diagnosis. The group of patients who do not know require particular care. It is important that everyone who comes in contact with them knows that the patient does not know his diagnosis.

The nurse in the hospital plays an important part because she is working directly with the doctor during the period of diagnosing and during the primary and essential part of the treatment. Whether or not she follows up the patient at home, she is in position to answer many of his questions and help with problems once the plan of treatment has been established.

Miss Keller: The hospital nurse has several major responsibilities in maintaining continuity of service to the cancer patient. This begins before the patient comes to the hospital, carries through his stay in the hospital, and continues after his discharge and his return to his home and community. The hospital nurse should find out what transpired before the patient came to the institution. She should become aware of his special fears and anxieties. At Memorial Hospital we made a study of several hundreds of patients and we classified their fears. First of

course is the fear of death; other patients have a fear of mutilation, of pain, and special anxiety about rehabilitation. The patient is concerned about his relationships with his family, his friends. Is he going to be able to return to his job? Will he be able to support his family? Will she be able to take on her household activities?

The nurse in the hospital must prepare the patient psychologically for the treatment he will receive—often of a radical nature. Much is being done along these lines in both special and large general hospitals. These patients, incidentally, are desperately ill and require the highest nursing skill. After the patient has begun to recover the nurse must teach him to care for himself. He is in some ways a different person. For example, a patient with a colostomy must learn to care for his new condition. He must be taught carefully in the hospital so that he may return home with some feeling of self-reliance. Even so he is so frightened by the difference in his situation when he returns home that he needs further instruction and guidance then from the public health nurse.

At Memorial Hospital we are bringing the public health nurses into the institution, as far as we are able, to see the patients before they are discharged so that the nurse who is to visit the patient in his home has a clear understanding of what is taught at the hospital.

Patients have many special problems to contend with. One man lived in a rooming house with very inadequate bathroom facilities. Since it was impossible for him to tie up the bathroom in the morning to irrigate his colostomy, he went to the Pennsylvania Railroad station every day and carried out his treatment in comfort and peace in the men's room.

Miss Peterson: I wonder sometimes if some of the things we say about the continuity of patient care isn't something we know we ought to be doing rather than what we actually are doing. We actually don't know how many patients need a home visit by a public health nurse. In a study made in Connecticut of some 2,400 patients it was found that about 75 percent of them needed home visiting. Yet in an unpublished report of the follow-up of forty patients discharged from a hospital in Washington, D. C., it was found all had needed nursing service and none had been referred for such service.

During the last year the Philadelphia Visiting Nurse Service collected data on its cancer case load for 1948. They had carried 746 patients. Information on these records was sent to the USPHS for analysis. It was found that only 18 percent of these patients had been referred by the hospitals for home nursing services; 19 percent were referred by private physicians and 61 percent were referred by the *families themselves*. So I really wonder if we don't talk a good deal about the continuity of care, about the whole patient, his physical, mental, and spiritual welfare, but actually are doing rather little.

The nurse in the hospital who has been giving the patient care and is familiar with his needs and what he has been taught is the one who can best make the referral to the community nursing agency. This recommendation was made by the Joint Committee on the Integration of the Social and Health Aspects of Nursing.[1] The physician, the medical social worker, the nutritionists, and other hospital personnel should have access to the referral slip and should incorporate in it any information or instruction which will improve the patient's care at home.

But a referral system should be a two-way system. The public health nurse in a generalized service who is alert and who has adequate knowledge about cancer recognizes early symptoms and is able not only to refer patients to the doctor but also motivate them to go. When such patients are sent to the hospital a referral report should come from the public health nurse also. This nurse knows about the home situation; what the emotional problems in the home are; what the opportunities are for sending the patient back home again; whether the patient will have someone to care for him.

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[1] Referral of patients for continuity of nursing care. PUBLIC HEALTH NURSING, November 1947, p. 568.

If the public health nurse is to be a member of the team, she must share her information with the doctor, nurse, social worker, and others in the hospital so that the best plan can be arrived at for the individual patient not only as regards his hospital stay but also his discharge.

Miss Thompson: The practical nurse enters into this picture also. She often cares for the cancer patient in his home for long periods of time. If we had a well developed team in every community—a team to care for the medical, nursing, and social problems of the patient—it would be fine. But often the practical nurse works pretty much by herself, getting her orders from the doctor but having to assume all the responsibility for caring for the patient alone.

The qualified practical nurse usually has twelve months' preparation. This isn't a long enough time for her to learn all the complicated things one has to know if the psychological factors are to be considered in caring for the patient. In addition, the practical nurse is not prepared to teach. We all have to think what we can do to help practical nurses who often are very close to the situation in caring for patients with long-term illnesses in their own homes. These nurses carry many responsibilities and usually have no supervision from professional nurses. The practical nurse who is a member of a public health nursing staff of course benefits from supervision but this worker is assigned on a visit basis and doesn't remain full-time in the home.

Miss Thomas: Patients in the hospital sometimes are unwilling or unable to express their fears or ask questions because they feel this may imply they are questioning the doctor's or the nurse's care. If they are naturally dependent they are afraid of offending the person in authority. Therefore a lot depends on the kind of person the patient is and has been before he became a patient. People don't stop having emotions because they leave the hospital. It seems to me, the practical nurse is particularly apt to get involved in the family's emotional factors as she practically lives in the home although she may sleep in her own home.

The patient has problems of a social and medical nature wherever he is, and these are of concern not only to the medical social worker but to all the members of the team. Because of the nature of cancer it is in many ways a family illness. Many patients are known for the first time when they come to the hospital. For them home care begins in the hospital. For others home care begins before hospitalization. It would be helpful to have the patient referred to the hospital social service department at the time his name is put on the waiting list for admission to the institution rather than after hospitalization or when he is nearly ready to go home. The social worker should know about the patient's home situation before plans are made for his discharge to his home. Is there someone to care for him? Will the patient be able to return to his work? Does he need vocational rehabilitation? How does the patient feel about not being a wage earner, about his wife or children going out to work?

What happens when the patient is the mother of the family? She is the one who usually takes care of the ill in her home. Who is going to take care of her? Who is going to be the mother? Can the burden of housekeeping chores be removed from her? Can the community provide nursing service—a public health nurse or a practical nurse? Can housekeeping aid be secured? Even if she is bedridden, can the mother retain the discipline of the children, the job of planning for the family? Can the children be helped to take their problems to her and not protect her leaving her out of all the activities that have made up her life?

I remember one instance in which a mother remained in her own home until the day before she died. She had all this extra time with her family and they with her. On this last day she said to the nurse who was visiting her, "Is this the time to go back to the hospital?" The nurse, with whom the patient had developed an excellent relationship, said, "Yes, this is the time." The patient went without regrets, knowing she had done all she could for her family. The social

worker had worked with the children, had found out what their fears were and helped them to face these. Other community workers had been brought into the home while the mother lived so that the children were familiar with them and did not have to make the additional adjustments at this time.

The person who lives alone presents other problems. Can he stay home? Will someone shop for him? Who can bring food in? Is an icebox needed? A neighbor may be willing to shop once a week but not every day. Does he need financial help? Are there adequate sheets, towels, comforts for the sickroom? Can these be secured?

Mrs. Sturgis: This does seem the time to talk about the volunteer services of the American Cancer Society. In fact, we must give some consideration to the volunteer as a member of the team. First, the society as a matter of policy can't spend much for financial aid to patients. There are specific budgetary priorities, and cancer research and education necessarily top the list. Educational activities and research will eventually, and in some instances immediately, pay off by detecting cancer early and saving lives. So although the state divisions of the American Cancer Society are not able to assist families with large sums of money, there are many other services of a neighborly nature which add greatly to the patient's comfort and the family's happiness.

The local societies maintain loan and gift closets. Dressings, sickroom necessities, and comforts also are available. The dressings are made by volunteers and the loan closets are usually cared for entirely by volunteer service. Most communities have a transportation service also. This frequently permits a patient to return home and attend a clinic instead of remaining in the hospital. Home visiting by specially trained volunteers is being tried out on an experimental basis. This will be started as local projects if the medical and nursing groups are in favor of it. It can be worked out only in cooperation with all the other team members.

Miss Cree: I'd like to get the school nurse on this team because she really belongs there. The nurse in the school works not only with school-age children and young people but also with teachers and parents. She visits in the homes too and has many opportunities for early case finding activities. In addition, through her interviews with the children the school nurse learns of illness in the home and can be instrumental in helping people secure medical care and remain under medical care. The school nurse can also be a good source for referral to other community services. The nurse working with lay groups, such as parent-teacher associations, can do much to advance community educational and planning programs for the control of many illnesses among which cancer control should have a prominent place. Community workers with a positive approach to cancer education should be working with curriculum committees in the school system, so that current information about cancer can be given to young people in a sound way.

Mrs. Turner: It is a new concept that the volunteer may have a place in the team caring for the cancer patient. Yet, we all recognize the fact that the professional personnel do not have the time for the various peripheral activities that have been mentioned, no matter how important you think these are. For instance, trained personnel should not transport a cancer patient to a clinic or hospital for treatment. Yet that patient quite frequently must have such service if he is to receive his treatment. Now, are you going to turn this patient over to anyone who can drive an automobile or do you want to know something about the person who is driving the patient to his destination? It is impossible for two people to drive for even a short period without entering into a conversation. Heedless conversation in such an instance can do much harm. This of course is only one aspect of the situation.

The average volunteer holds the medical profession in almost as great awe as she holds the leaders of her religion. Therefore, she is timid in their presence and shows little initiative unless coaxed, drilled, and trained by someone in authority. The ideal person to

undertake this training is the graduate nurse who is inactive professionally and who can participate in the program on a volunteer basis. Such nurses can make a tremendous contribution in their communities. They understand professional standards, ethics, the function and role of the various members of the team. Being secure in their professional knowledge, they do not have the inhibitions of the usual volunteer; although retired, they still may have the satisfactions of serving.

Mr. Peterson: If we are to have teamwork we must first learn how to train the team and how to form the team. This requires participation by all the members of the team—doctors, dentists, nurses, social workers, various public health officials, and volunteer workers. Any one of these, the nurse, the volunteer, et cetera, working with the team, must know the rest of the team, have confidence in them, and understand their points of view. To carry out this program we must be sure those who are giving the training to any of the team know the cancer control program and know the total needs of the patient. Many professional people, doctors, dentists, nurses, need refresher courses in cancer if they are to participate constructively as members of the team.

There is another important person—important in the total care of the cancer patient—the spiritual leader. In many of our communities there are no public health nurses; the family physician may not be easily available. The local volunteer and the minister may very well be closest to the patient and his family.

If a cancer control program is to be provided in a community and if services are given by several organizations or groups, then these services should be coordinated. The official health agency most certainly feels its responsibility for bringing about this coordination. Every worker, regardless of the agency he is connected with, must understand the role of the others in the team and all must work under the direction of the patient's physician. Each one must have a realization of the total needs of the patient—medical, physical, emotional, social, and spiritual.

Dr. McClusky: In the course of this discussion the point has been made several times that although cancer in many respects presents problems similar to other chronic diseases and efforts should be made to coordinate community plans and services to study and care for all these diseases, cancer from a psychological point of view produces problems peculiar to itself. Attitudes towards this disease in spite of all our efforts to achieve a positive approach have overtones of desperation.

In the final analysis, all of us who are part of the team concerned with cancer patients should examine our own attitudes and determine how positive and constructive is our own approach to the problem of cancer.

At this point in the meeting the audience divided themselves into small groups and discussed for a short time aspects of the subject and of the panel's comments of special interest to members of the group. Each group formulated at least one question; naturally there was duplication in the questions. Because of the time factor only a small number of the questions were considered at the meeting. The deep interest in this indicated how close the topic of cancer is to all community workers.

Questions

How can we set up a comprehensive referral system that would be used by all the workers in the community concerned with the care of the cancer patient—a system that would encourage sharing of all essential data important for the understanding and care of the patient?

Would it be possible to have routine notifications from hospitals to the public health agencies when a cancer patient is admitted to the hospital?

How does the public health nurse get into the hospital to learn about the patient before his discharge?

How can private physicians be helped to realize the need for giving their findings to hospital, public health, and other workers involved in the team?

Through what channels can we seek the volunteer nurse?

What would be the role of the inactive nurse in this program? What kind of training would be required before she could be valuable?

Why shouldn't a volunteer give bedside nursing care in the home, within the scope of her knowledge and training, where no other facilities exist?

Can a definite training program, including recreation, home care, morale building, et cetera, be established for volunteers who will enter the home where a cancer patient is being cared for?

What are the legal responsibilities of volunteers in transporting patients in their own cars?

If a patient on a low income assumes the responsibility of transporting himself to the hospital two or more times a week by taxi, should we try to assist the family in arranging for some volunteer agency to transport the patient?

What efforts are being made to set up a housekeeping service for those families able to pay none or only part of the cost?

Is any financial assistance available for patients needing costly treatment such as x-ray or radium therapy?

Discuss methods that might be used to keep patients who are reluctant to accept care under continuous medical supervision.

How much responsibility does the doctor assume for continuing care and keeping up the morale of the terminal patient in the home? And does too much responsibility fall on the public health nurse, family, or whoever cares for the patient?

Should a terminal cancer patient be left in the home where there are children?

How much responsibility should school children be given for educating their parents about cancer? At what age should children be given this information?

How can the members of a family be helped to adjust to a poor prognosis?

What is the role of the public health nurse in the home where the patient is being cared for by a practical nurse?

How does the American Cancer Society plan to get the teamwork concept impressed on the local and state cancer society? How can we foster better coordination with the state and local society?

Why isn't the program of the American Cancer Society more active in the local community? Whose responsibility is it to interpret the program on the local level?

Is it the policy of the local cancer society to work closely with local health agencies and is this part of the training of all personnel connected with the society?

The public health nurses in a cancer detection center are aware of an apparent lack of appreciation on the part of the volunteer and medical group as to how public health nurses are prepared to function. Who might best undertake this interpretive role?

Inasmuch as most of the problems mentioned in this discussion are inherent in other chronic illnesses would it not be better to develop community teamwork to meet the needs of all chronic illnesses instead of placing so much emphasis on cancer?

The Nurse Mental Health Consultant

Functions and Qualifications

SINCE THE PUBLICATION of "Public Health Nursing and Mental Hygiene"[1] in October 1949 the project described in that report has been carried further under the terms of a continued grant from the National Institute of Mental Health, Public Health Service, Federal Security Agency. The grant is administered by the National League of Nursing Education in cooperation with the National Organization for Public Health Nursing. The joint project is concerned with bringing together information of mutual interest and help to psychiatric and mental health nursing personnel. One objective is to examine the practices of both groups of workers and to publish statements of their functions and desirable qualifications.

In the formulation of this statement concerning the nurse mental health consultant an effort was made to collect and present the opinions of persons experienced in the use of services of such consultants, of consultants themselves, and of educators and others with special interest and experience in the preparation of consultants in this field.

Data are also being collected to provide the basis for a similar statement on the functions and qualifications of psychiatric nursing personnel and to add to the growing fund of knowledge needed for other aspects of the overall project. Eventually it is planned to issue a joint publication describing functions and qualifications in terms common to both mental health and psychiatric nursing personnel.

This statement should be regarded as one step toward the publication of a unified statement of objectives for the application of psychiatric knowledge to all aspects of nursing.

THE PATTERN of employment of nurse mental health consultants is not yet fully established. Such workers are now employed by both voluntary and official agencies. The following partial list will give some indication of where their services are being used: public health nursing associations, basic and advanced programs of study in nursing education, mental health programs for nursing in federal agencies; state, county, or city departments of health; state, county, or city departments of education; mental hygiene clinics.

The role of a nurse mental health consultant is necessarily influenced by the administrative setting of her work as well as by the established objectives of program of the agency or unit in which she functions.[2] In general, however, she seeks to develop in nursing a more thorough, a more basic, and a more conscious conception of human behavior. This is in keeping with currently accepted concepts that the emotional and somatic components of the individual are indivisible.

[1] Pease, Sybil H. *Public health nursing and mental hygiene,* PUBLIC HEALTH NURSING, October 1949, p. 521.

[2] More specific information about the development of activities of the nurse mental health consultant may be obtained from the respective state directors of public health nursing services.

Functions[3]

In many of the functions listed below the nurse mental health consultant shares responsibility with others. It is expected that her unique contribution is on the basis of her heightened understanding of human relationships, of special skills in leadership, and of better than average skills in communication methods.

1. To emphasize opportunities in the practice of public health nursing for the promotion of mental health and the possible prevention of emotional disturbances.

2. To increase effective use by nurses of: existing psychiatric, psychological, and social diagnostic services; follow-up services; related community health, educational, and welfare services, all of which have a part in community mental health.

3. To strengthen recognition in nursing education and practice of the need for the personal and professional growth and maturity of the nurse.

4. To participate in the conduct of mental health studies and surveys.

5. To serve as liaison in her specialty with groups within the nursing profession, with other professional groups, and with the community.

6. To further the education of the public in relation to mental health and to share in the stimulation of development of needed resources.

Recommended Qualifications

PERSONAL

All the foregoing functions imply certain skills, understandings, and personal qualities in the individual who assumes the duties of nurse mental health consultant. Personal qualities are the most difficult to define or evaluate because of their subjective nature. Yet, they are the most important aspects of competence. Perhaps the best way of deciding that a person possesses desirable personal attributes is to pool the opinions of persons who have knowledge of her behavior in various situations.

Essential qualities which have been clearly demonstrated might be: ability to work constructively with others, flexibility, sound judgment, ability to share responsibility, integrity, enthusiasm and sensitivity which can be used for the benefit of others.

PROFESSIONAL

1. General education—college degree.

2. Graduation from an accredited school of nursing.

3. State registration.

4. Completion of a program of study in public health nursing approved by the National Nursing Accrediting Service after 1949, or prior to that date by the National Organization for Public Health Nursing.

5. Five years of nursing experience: two of which should have been in an organization administering a family health program; one of which should have been as a staff nurse working under qualified supervision; and two of which should have included teaching or supervisory responsibilities.

6. Satisfactory completion of a special pro-

[3] Many listings of functions of workers are in terms of what may be called "methods," such as preparation of manuals, observation of services, et cetera. Such listings are purposely eliminated here and the term function is conceived to indicate an interpretation sufficiently broad to permit filling in by the reader's own imagination and experience.

gram of advanced study and learning experience on a master's level or beyond.[4] This provides opportunity to develop previously obtained professional knowledge and skills.

So far as methods of carrying out her functions and objectives are concerned, one can only say the nurse mental health consultant uses whatever method seems appropriate to the situation. However, it is expected that her strengthened understanding of human relationships will sharpen her judgment as to choice and timing of methods.

[4] For names of institutions offering these specially designed programs, write to NOPHN, 1790 Broadway, New York 19, N. Y.

This statement was prepared by the NOPHN Mental Hygiene Committee. The members of the committee in 1948-1950 were: Milenka Herc, Chairman; Ruth Gilbert, Sybil H. Pease, Lucile Petry, Lillian Salsman, Dr. George S. Stevenson, Pearl R. Shalit, Margaret S. Taylor, and Ruth G. Taylor; Mary L. Foster, Secretary, part-time; ex officio, Ruth W. Hubbard, Anna Fillmore, M. Olwen Davies.

References Which May Be Useful for Further Understanding

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Public Health Nursing Studies and Inservice Education

CLARA B. RUE, R.N.

"STOP! LOOK! LISTEN!" is a familiar sign often seen at railroad crossings. Similar thoughts are appropriate for the public health nurse as she crosses the threshold of the home. The success of the nurse in health service to the family is dependent upon her ability to make good observations, maintain an alertness to the feelings and desires people have in relation to themselves, and to ascertain in light of these facts what her role in the situation shall be.

Those responsible for the inservice educational program of the new staff nurse are constantly searching for practical methods which may be useful in helping her to become a productive participating member of the group as early in her experience as possible. This entails the acquisition of a working knowledge of agency policies, a working relationship in the community, as well as a mastery of the agency's service procedures. How the educational program of the agency affects the individual nurse during the orientation period is markedly influenced by her past life experiences, professional and social. Whatever happened to the nurse as a student in the school of nursing has direct bearing on her introduction to the public health nursing program. Traditionally the drive in nursing is for physical action. The scale of values is overbalanced in favor of the physical care of the patient rather than the whole person. Doing for the patient even to the point of unconsciously annoying him is often more favored than taking time to see how he feels.

Overeagerness to be doing or teaching has a tendency to limit discriminating observations. Consequently a nurse may get into action and under way before the patient's needs are fully understood. Furthermore health needs in the home are easily disguised because of the individuality of the family as a whole and also of its members. Disciplined observation powers need to be cultivated in order to deal successfully with these factors.

Attentive listening professionally is widely stressed in public health nursing. And yet the time is not far in the past when the nurse was expected to be doing something more obvious for the patient than listen to him talk or complain. So deep-seated have these mores become in the nursing profession that much effort is necessary if the average nurse is to develop into a competent listener.

Stop to plan; look at the individual needs; listen to the interpretations and wishes of the family. Skills in these areas are not among the simpler responsibilities of the public health nurse. This paper describes one method used during the orientation period to help the staff nurse develop keener observation habits, interviewing technics, and ability to study case material analytically.

The nurse selects for study a specific health condition or service which especially interests her. Subjects chosen are usually those in which she feels less adequately prepared and in which the role of the public health nurse is not so well understood as in some other areas. These include: rheumatic fever, cancer, diabetes, geriatrics, arthritis, early ambulation in maternity, and several others.

A work guide is available for her use. Objectives are set up indicating the range of the study and a study sheet is prepared on which to classify specific and meaningful

RHEUMATIC FEVER STUDY SHEET

Objectives: 1. To study status of and the conditions which surround a patient with rheumatic fever in the home.
2. To study the day by day program of the patient with rheumatic fever.
3. To study community facilities and program for rheumatic fever.

Case Number	Members of Family	Socio-Economic Conditions	Health Status of Members of the Family	Sex of Patient	Age	Age at Onset of Rheumatic Fever	Past Health History and Progress of Illness	MEDICAL SUPERVISION: Date First Seen by Doctor	Interval of Contact with Doctor in Home or Office	Orders	Period of Hospitalization, if any	Daily Routine and Health Habits

Schedule of Physical Activities and Rest	NURSING SUPERVISION: How Referred to VNA	Nature of Service Rendered	Interval of Visit	Period of	Fee Basis	Competency of the Attendant	Adequacy of Care and Teaching Success of Visiting Nurse	Adjustment of Patient and Family to Illness	Other Special Factors Such As Rehabilitation	Community Services Used

Sample of a study sheet

facts and observations. In addition to assembling case material on the study sheet, the nurse concurrently investigates community resources and planning and other significant developments in the area of the study. She assembles reference material and reports on contacts with agencies and other pertinent information for the benefit of the staff as well as herself.

IN AN AGENCY where there are several nurses in a branch office, the project encourages the new nurse to make contact with the other members of the staff in relation to case material within the scope of the study. Interest in and discussion of the subject are promoted and the new nurse is drawn early into the group.

Data are accumulated on the selected subject until such a time as the nurse is prepared to make a satisfactory report to the staff. This may be six months, eight months, nine months, or a year. In the meantime she may give a progress report to a student and new staff group.

The project also has possibilities for interpretation of patient and family needs to community groups. For instance, a new staff nurse prepared a field study on "Early Ambulation in Maternity Patients." A progress report was given during the orientation period. The study was continued and with the cooperation of other interested members of the staff, information about 160 patients was included on the study sheets. The study items were evaluated and the report presented at a staff meeting. It was an excellent report, interpreting the needs of the maternity patient and her baby. The nurse was asked to present the study at a local meeting of pediatric and obstetric supervisors. Later a condensed form of the study appeared in the State Board of Health *Bulletin*. Recently the nurse participated in a panel discussion of "The Psychological Needs of the Newborn," presenting observations made in her work. The other participants on the panel were obstetricians, pediatricians, and institutional nurses.

Projects such as this lead the nurse into group participation and are a helpful means of promoting good staff relationships. The study sheets are kept on file in the branch offices and a nurse wishing to assemble material for a report on any one of the areas which have been studied may combine this material with her own and use it in whatever way may fit her need.

The project just described is only a part of a staff education program. Its value as such may be briefly stated:

1. Encourages systematic methods of comparing situations and findings in public health nursing.
2. Clarifies thinking through disciplined tabulation of observations.
3. Promotes more analytical study of situations encountered.
4. Stimulates group action and leads to improved action by the group.
5. Gives the young nurse professional satisfaction early in her professional experience.
6. Improves the performance of the nurse in observing, listening, interviewing, and planning.

Miss Rue is associate director, Visiting Nurse Association of Milwaukee.

Report of Regional Conference

We have on hand a number of the Summary of the Proceedings of the NOPHN Regional Conferences held in December 1949. Orders will be filled at the reduced price of 25 cents a copy so long as the supply lasts. Write to NOPHN, 1790 Broadway, New York 19, N. Y. Enclose coin or stamps as this reduced price does not include bookkeeping costs.

Bellevue Hospital's Home Care Transfer Program

JUDITH ABRAMSON, R.N.

SOMETHING NEW has been added to the traditional hospital scene. Every morning outside of Bellevue Hospital, a car with chauffeur can be seen in waiting. On its doors there appears the name "Bellevue Hospital Home Care Service." Into the car there goes a team of hospital employees for transportation into the community where hospital patients are visited. Doctors, social workers, physiotherapists, and occupational therapists, as needed, comprise this team. And from nearby district offices of the Visiting Nurse Service of New York, nurses plan their visits to Bellevue Hospital patients who have been returned to their homes under the supervision of the Hospital's Home Care Transfer Program.

Home care, as the program has come to be known, is designed for patients who no longer require the specialized facilities of a hospital but still need active medical and nursing care. For medically eligible and indigent patients who have a home, one to which they want to go and where they are wanted, the hospital extends its services.

Overcrowding of hospitals has long been a problem to hospital administrators. Wards are crowded with patients with cardiac diseases, patients with fractures, amputations, et cetera, for whom only a minimum of medical and nursing care is needed. Such patients, however, are not well enough to be discharged and they occupy beds sorely needed for new acute cases. With both population and prices increasing, the problem of caring for the acutely ill has become intensified. Hospitals are costly institutions if considered only from the point of view of construction, operation, and maintenance.

The scheme of extending hospital care into the home seems to relieve not only the problem of availability of bed space but that of adequacy of personnel.

Montefiore Hospital, a voluntary hospital in New York City, had its Home Care Program in operation for approximately two years when the City of New York initiated such service. This was in November of 1948 when five city hospitals under the auspices of the Department of Hospitals undertook the task of transferring home and giving service to a combined total of 1,000 patients.

After a trial period of six months the commissioner of hospitals, Dr. Marcus D. Kogel, announced, "Home care is here to stay." Similar programs were thereupon launched in nine additional municipal hospitals. There are more than 1,000 patients receiving home care at this time under the supervision of the Department of Hospitals. Translated into terms of an institution with a comparable bed capacity, the enormity of this undertaking can readily be appreciated. In addition to the enthusiastic physical and emotional responses of the patients, the factor of cost is gratifying and impressive. Hospital ward care for 1,000 patients would require the construction of a $20,000,000 hospital whose operation would cost an additional several million dollars annually.

Computation of the cost of operating this program during 1949 indicated a per capita

Miss Abramson is nurse coordinator, Home Care, Bellevue Hospital, New York.

per diem cost of $2.66. This was about one fourth of the current daily cost for general care in the wards of the municipal hospitals. The principal home care services given 1,001 patients included 12,000 home visits by physicians, 28,000 visits by visiting nurses, 3,500 visits by medical social workers, 5,400 visits by physiotherapists, 200 visits by occupational therapists, and about 57,000 hours of housekeeping service. Since not every patient needs all these specialized services, such as a daily visit from the visiting nurse, the costs were prorated.

As THE PROGRAM has been conceived and practiced, hospital services are provided to patients in their homes on a basis equal to or exceeding what they received in the hospital. It has thus been the responsibility of the Department of Hospitals to plan a broad program of services necessarily encompassing every phase of care. Patients on home care relieve the hospital of cost of maintenance, but such supplies and equipment as beds, mattresses, pillows, wheel chairs, bedpans, and basins are loaned to them. At the end of their home care when patients are either discharged as well, referred to the outpatient department, or returned to the hospital, their families are responsible for returning all supplies and equipment.

An additional service given on home care is housekeeping. The home care budget allows 75 cents an hour for housekeeping service for patients who need help in cleaning, shopping, and cooking. The social worker in evaluating a patient's home situation confers with the physician regarding the amount of activity the patient is permitted. When housekeeping assistance appears to be indicated, that is when a patient with limited ambulatory privileges either lives alone or is alone a good part of the day, arrangements are made by the social worker to secure such help. Friends or neighbors of patients are frequently employed for this work. Housekeepers are under the supervision of the social worker who authorizes payment and makes spot checks in the home. The number of hours authorized is determined on an individual basis through the joint evaluation by the doctor, nurse, and social worker on the Home Care Program. This service makes it possible to transfer many patients who would otherwise be ineligible for home care.

In their Home Care Programs participating hospitals are guided by the same overall policies although practices vary somewhat from one hospital to another. For the larger hospitals such as Bellevue an objective of a two-hundred-patient case load has been established. Since the program has been designed principally for acute rather than chronic cases, it will be recognized that the service is an active one. The daily census fluctuates considerably.

A significant feature of the program is the patients' status. When they are placed on home care they are not discharged from the hospital but rather *transferred* to this service. Patients are thus carried on the hospital census while at home. The Home Care Service is an inpatient activity and therefore well integrated with all other phases of the hospital's administration. The facility with which the program operates is perhaps due to the fact that the Home Care Transfer Program can be thought of in terms of another ward to which patients are transferred.

THE PERSONNEL of the Home Care Department consists of six assistant resident physicians, a nurse coordinator, social workers, four physical therapists, four occupational therapists, two stenographers, two clerks, and two attendants. All of these with the exception of the social workers are under the immediate supervision of the deputy medical superintendent in charge of the Home Care Program. Social workers from the various wards from which patients are recommended for home care follow their own patients. All nursing service to Bellevue Hospital home care patients is rendered by the staff of the Visiting Nurse Service of New York.

Working closely with the deputy medical superintendant is a nurse coordinator who is active in the planning of all phases of the patient's nursing care. A public health nurse, she is the liaison worker among all the personnel concerned with the patient on home

care and one of her principal responsibilities is the development of procedures relating to nurse participation in the Home Care Program. She is responsible for interpreting the Home Care Program to the institutional nurses and for planning and executing an educational program for them. These activities are directed toward stimulating and developing the interest of the institutional nurses in patient-teaching so that they may prepare patients for going home and receiving necessary continued care. Since the nurse coordinator is responsible for expediting the exchange of information between the hospital nurses and the visiting nurses, it is necessary for her to familiarize herself with every patient's needs since she relays to the visiting nurses the observations of the nurses on the wards. In addition to obtaining specific medical orders the nurse coordinator must obtain information about the patients' behavior on the wards, significant relationships with family, other patients, and hospital personnel. She must know their attitudes toward their illness, the degree of responsibility they assume for their own care, existing food fads, as well as their physical needs. She interprets to the hospital nurses the activities, policies, and practices of the visiting nurses.

The nurse coordinator maintains continuous contact with the Visiting Nurse Service since under terms of a contract between the City of New York and the Visiting Nurse Service of New York, all patients on home care are visited at least once by a visiting nurse. Specific orders from the physician sometimes require that patients receive periodic visits, for instance, for intramuscular injections. Other patients are carried for health supervision, interpretation of a special diet, and other medical orders.

Although all communications between the visiting nurses and the nurse coordinator are confirmed in writing, there is nevertheless frequent need for telephoning. The visiting nurses report by telephone conditions they find in the homes which require the immediate attention of the Home Care Department.

Patients accepted for home care who live outside of Manhattan are carried on the Home Care Program of the municipal hospital nearest their homes and referrals are forwarded by the nurse coordinator to the public health agency which has contractual agreements with that hospital. For example, a patient residing in Brooklyn in the Kings County Hospital district is visited by a nurse from the Brooklyn Visiting Nurse Association and carried on Kings County Hospital's Home Care Program.

CERTAIN PHASES of rehabilitation are carried out in the home by occupational therapists and physical therapists under the supervision of the hospital's rehabilitation service. Patients are evaluated by that department before their transfer and are returned to the hospital for consultation as required.

Four physiotherapists on the staff help patients with fractures to crutch walk and stair climb; hemiplegias are aided to ambulate from bed to chair and to feed themselves; neurological patients are helped to assume more responsibility particularly in going to the bathroom. Massages, exercises, hot packs, and electrical stimulation are but few of the procedures conducted in the homes. The visiting nurses caring for the Bellevue patients sometimes give such procedures as hot packs, but in general they are relieved by the physiotherapists of orthopedic activities.

Four occupational therapists perform additional rehabilitation services for patients who might otherwise dwell upon their illness, feel themselves to be burdens on their families, and consequently develop an acute episode which would necessitate their return to the hospital and thus confirm their unwarranted fears. Everything from looms to knitting needles is sent to the patients, many of whom become so proficient in their skills that they are able to market their products with the assistance of the therapist.

Community agencies are quite active in this phase of the patients' care, and often take over completely when the patient is discharged from home care. The New York Association for the Blind is one example. The Board of Education sends visiting teachers

to homebound children, the Department of Welfare supplies many recommended services to patients on its rolls, and the Red Cross has assisted in the transportation of patients to vocational rehabilitation centers. All contacts with community agencies are made through the social worker who is actively working with the patient. Patients are visited by assistant resident physicians who are assigned to the Home Care Program on a rotating basis. Since emphasis is placed on continuity of medical care, whenever possible patients are seen in their homes by physicians who knew them on the ward. The frequency of visits is determined by the physician on an individual basis, but usually it is not less than once every week or ten days. Physicians are transported by car which makes it possible for them to carry a heavy and well equipped bag. A portable electrocardiograph machine is in the car for ready use. If in the judgment of the physician the patient is found to require a transfusion, a paracentesis, clysis, or any specialized treatment, the patient is returned to the hospital by ambulance. Patients are similarly transported for certain examinations, such as x-rays and laboratory studies. An ambulance and two attendants have been specially assigned to the Home Care Department for this purpose.

Two clerks and two stenographers take care of the multitude of clerical details necessary to the program. Considerable contact is maintained by telephone with patients themselves, members of their family, and workers in the field. Accurate recording of telephone messages and subsequent follow-up are clerical responsibilities. In addition the recording of physicians' follow-up visits to patients, the transmittal of written orders to the visiting nurses, the recording of social workers' reports, and many other phases of patient services rest with these clerks and stenographers, who are under the close supervision of the nurse coordinator and deputy medical superintendent.

Social workers who are assigned to the various wards throughout the hospital attend to the social service aspects of home care cases referred from their wards, both prior to and following transfer. Working with the family and the patient, they investigate attitudes toward such a plan of care, determine the adequacy of the home itself and the financial assistance required in order to make such a plan practicable, and try to aid the family in making the many adjustments necessary in assuming this added responsibility. A summary of the findings and recommendations of the social workers is dictated and typed, and finally becomes part of the patient's chart. Home care patients' charts are kept in the Home Care Department and remain active as long as patients are carried on this service.

CASE FINDING begins on the ward. Doctors, nurses, physiotherapists, occupational therapists, and patients themselves are encouraged to think of all patients as possible candidates for home care from the day of admission. It is the physician, however, who prepares the written recommendation for home care for a patient on his ward. His essential criterion is that the patient requires a minimum of medical and nursing care which in his opinion can be given adequately at home. Before submitting the recommendation form to the Home Care Department he usually consults the social worker to determine whether there is a home to which the patient can go.

The financial status of the patient is the next consideration. The names of all recommended patients are cleared through the financial investigator who makes the decision. Only medically indigent patients are accepted for home care. Patients who pay over $2 a day for hospital care are immediately disqualified on the grounds that they can afford a private physician. A similar ruling applies to compensation and liability cases and to participants in the Health Insurance Plan of Greater New York. The policy is a tentative one and is under study since obvious discrepancies exist with regard to patient care and its relation to cost.

If accepted financially the patient is then visited on the ward by the chief resident physician on home care. If his approval is given, the social worker then takes up the

case for evaluation of the social situation. When the worker has completed her evaluation, usually within a week from the time the recommendation was submitted, a final determination is made as to the acceptance or rejection of the patient for home care. The case is presented at a home care evaluation committee meeting which is held twice weekly and attended by the entire home care personnel. Nurses are encouraged to attend these conferences particularly when cases known to them are being evaluated. At this time all phases of the patient's care are reviewed and discussed. If the patient is considered an acceptable candidate the transfer is usually arranged for the following day and the ward is notified accordingly. Should the patient be rejected for medical, nursing, or social reasons, the recommendation form is returned to the ward with an explanation for the rejection. The form is then incorporated in the patient's chart.

Participation of the ward instructors and student nurses in the conference has been found to be a valuable experience. The nurse who knows the patient is able to contribute to the group information which is pertinent to the planning under way. The nurse in turn is stimulated to think of patients from a perspective all too often neglected. She gains a heightened awareness of the needs of all patients for preparation for return home and the ways in which she can contribute to the patient's successful adjustment to his illness at home, and she becomes familiarized with the role that the visiting nurse will assume. The visiting nurses are invited to participate in the discussion of patients, particularly those already known to them.

NOT ENOUGH can be said regarding the importance of participation by nurses, particularly student nurses, in the evaluation conference. This is a unique opportunity for the nurse coordinator to direct attention to the totality of preparation which enters into the planning prior to each patient's transfer to home care, since all patients are reviewed from a medical, nursing, and social point of view. By inviting to the conference nurses who know the patients, the discussion becomes pertinent and more meaningful, and teaching points of specific and immediate importance are made. Following the conference the nurses and the nurse coordinator discuss more fully the information to be transmitted to the visiting nurses. It is usually at this point that the students, ward instructors, and others most fully appreciate how they might better prepare their patients for return home on home care or otherwise. For example, the nurse coordinator led a discussion regarding a patient who had been admitted to the hospital numerous times in diabetic coma. It was revealed that no one had previously thought to inquire who gave this patient her insulin, who prepared her meals, when her eyeglasses had last been examined, what her home situation was, whether the patient knew anything at all about her illness, or whether the patient bore any type of identification to indicate that she was a diabetic.

Experience has proven that extremely careful scrutiny of the patient's total needs is a prerequisite to his acceptance on the Home Care Program. For example, if a patient does not want to go home but is forced to do so by a doctor who believes that continued hospitalization is not urgently needed, the patient will invariably develop an acute episode within a short period of time and be readmitted to the hospital. Adequate preparation of the patient and interpretation to him of the service he may receive as a home care patient may delay the patient's transfer, but the investment of time has been found to be worthwhile.

Preparation of the family must similarly be considered. Let us take as an example Mrs. C., a sixty-five-year-old woman with diabetes mellitus and cataracts who had been admitted for an amputation of her left leg. She had been receiving daily dressings to the stump, instructions in crutch walking, protamine zinc insulin before breakfast, daily urine examinations for glucose, and a C-150 diabetes diet. Continued medical and nursing care were obviously required, but the patient couldn't afford to have a private physician visit her at home nor could she conceivably travel to the clinic. She was deeply depressed at the thought that she would be

transferred to a hospital for chronic patients where she would spend the rest of her life.

When after two weeks of hospitalization Mrs. C. was asked by the resident physician if she would like to go home and have the hospital come to her, the response was enthusiastic. The fact that she had lived alone proved to be no problem since the social worker had ascertained that Mrs. C.'s daughter could take her into her home despite the fact that she had two young children. It was explained to Mrs. C. that the Home Care Transfer Program had arranged to send a housekeeper into the home for several hours each day. This caused Mrs. C. to feel less like a burden and made the plan feasible for her daughter. A description of the additional services rendered by the Home Care Program further alleviated the anxieties of the patient and her family. Arrangements had been made to lend a bed, mattress, pillows, and a wheel chair. A consultation was held with the hospital's Rehabilitation Service, and orders were given for a physiotherapist to continue crutch walking instruction in the home. An occupational therapist was assigned to give diversional therapy, such as teaching the patient to make clothes for her grandchildren thereby diverting her morbid interest in her infirmity and making her feel like a useful member of the household. Furthermore the social worker planned to continue her visits to assist in diverse family problems.

MEANWHILE DURING visiting hours the daughter had been receiving instructions from the ward instructor in the administration of insulin and the testing of urine for glucose. In order to ascertain that adequate care could be given in the home the visiting nurse was asked to see the daughter in her home before the transfer. The daughter responded well to the visiting nurse's confidence in her. She was reassured to learn that the nurse would make frequent visits to assist and supervise her in caring for her mother. Long-term planning for the administration of insulin had been insured and arrangements made for the visiting nurse to do the surgical dressing every other day.

With the assurance that a nurse and doctor would visit the following day, Mrs. C. was taken home in an ambulance accompanied by two attendants and all her medications, surgical supplies, and equipment including a mimeographed copy of her diet and instructions for maintaining contact with the home care personnel.

Patients are encouraged to get in touch with the Home Care Department should any problems or need arise. They are assured that there are doctors on call at all times. Prescriptions are left at the home by the physicians on their calls and are refilled by a member of the family at the hospital pharmacy.

Surgical supplies are replenished by the nurse coordinator who knows the types of materials needed by the public health nurse for a particular patient. Diabetics, for example, require replacement of insulin syringes, needles, cotton, test tubes, and medicine droppers. These are made up in kits and given to each diabetic on his transfer from the hospital. Similarly, every patient requiring intramuscular injections is given a 2-cc syringe and needles. While it might appear that this task could be delegated to a clerk, it has been demonstrated that the nurse coordinator's familiarity with the public health nurse's needs makes her best suited to anticipate the needs.

As has been pointed out, close contact is maintained between the Visiting Nurse Service and the nurse coordinator. All orders transmitted by telephone are confirmed in writing. The Greater New York Inter-Agency Referral Form is used for this purpose as it is designed to give the visiting nurse a complete picture of the patient. It includes medical diagnosis, prognosis, and orders; a report by the hospital nurse of the patient's significant attitudes, behavior, and needs with regard to the illness; a report by hospital dietician, physiotherapist, and occupational therapist, and a social service summary. The form is initiated by the nurse coordinator who is responsible for its completion and prompt transmittal to the Visiting Nurse Service. It is prepared in triplicate. The first two copies are forwarded to the Visiting Nurse Service while the third is retained by the Home Care Department as a work sheet.

Following her visit to the patient, the visiting nurse returns the second copy to the nurse coordinator with her findings and plans entered in the designated section of the form. This is incorporated in the patient's chart and becomes an integral part of his permanent record. The form is completed by the nurse coordinator on the ward with the assistance of a nurse who knows the patient. This procedure serves to further integrate policies and practices of the institutional and visiting nurses.

THE NURSE COORDINATOR reviews all the reports returned from the Visiting Nurse Service. This enables her to evaluate the total nursing care. She reports developments to the Deputy Medical Superintendent and submits to him recommendations regarding medical orders, social problems, equipment needs as far as nursing procedures are concerned, and nutritional, occupational, and physical therapy problems. As long as the patient remains under the active supervision of the Visiting Nurse Service the nurse who is carrying the patient is informed by the nurse coordinator of subsequent findings of the physicians and of additional orders. These are sent on continuation sheets of the referral form. A continual exchange of information is actively maintained in this fashion.

The assistant resident physicians who visit the home care patients read the inter-agency referral forms and communicate with the visiting nurses through the nurse coordinator. They incorporate in their progress notes changes in orders and pertinent information for the visiting nurse, rather than leaving notes for the nurse in the home. During their affiliation with the Home Care Transfer Program the physicians develop a much keener awareness of the services of the visiting nurses and an appreciation of the teamwork that makes this program not only feasible but so infinitely successful in terms of excellent medical and nursing care. While at the inception of the program considerable resistance was encountered on the part of the physicians, they have come to accept it as an invaluable experience in their medical training. What these physicians were at one time ready to denounce as "the beginning of socialized medicine," they now appreciate as a real community service, an alleviation of the crowding on the wards, and an opportunity for them as physicians to relate their medical knowledge to the social, economic, and emotional problems that are part of the patient's illness. Since the physicians rotate on a monthly basis, they return to the wards with added insight and a new interest not only in recommending other patients for home care but also in giving more consideration to their patients as human beings rather than diagnosed cases.

It is anticipated that at some future time the experience may be extended to student nurses of following up in their homes patients known to them on the wards.

In conclusion, it is satisfying to remark that the great majority of patients have shown remarkable and even dramatic progress under this plan of care. Of the great number of cases thus far transferred to the Home Care Transfer Program only a few have made excessive demands. There have been a relatively low number of readmissions and a very few deaths. Although the potentialities of this program are yet to be fully explored, the goal of better care to more patients has been achieved and an opportunity for the practice of public health nursing principles has begun to make itself felt within the walls of the institution.

Abstracts . . .

MANNERS

One of the most scathing criticisms that can be leveled against our children and young people is that many of them seem crude, crass, and lacking in the most common courtesy, Emily W. Rautman and Arthur L. Rautman, Ph.D., write in an article "Is Your Child Well-Bred?" in the April 1950 issue of *Mental Hygiene*.

However, despite their sometimes crude behavior, the writers continue, those of us who have worked with these children believe that they earnestly want to learn to be acceptable in the world. Because it is only through sympathetic understanding that we can help these youngsters, many of us are interested in finding out the why of such incidents as near riots after athletic events or vulgar behavior on the way to school.

Much of the control that society exercises over the behavior of its members has always stemmed from deeply ingrained codes regarding personal relationships. Codes also develop around places of specialized activity such as churches, hospitals. The youngster of today, however, is growing up with much less of this "place-consciousness" and long-standing familiarity with group codes than did his elders, largely because of the diversity of our activities in modern life and our greater mobility in living. Often moving from place to place and from school to school, our children have far less of the feeling of group loyalty which served to stabilize earlier generations. Furthermore, our mechanisms of entertainment have given our children inadequate practice in responding to face-to-face situations and have even given them actual practice in rude behavior. The radio, for example, is often switched off while the speaker is in the middle of a sentence. At the movies, entrances and exits during the performance are taken as a matter of course, as is eating popcorn or petting.

These factors have been reinforced by some features of our social and economic structure. We have crowded ourselves into apartment buildings at the same time that we have been perfecting ourselves as members of an extremely competitive society where courtesy is often taken as a sign of weakness. All these factors have tended to place our behavior on an impersonal rather than a personal basis.

Because good manners are just as important today as a generation ago, most of us are interested in the process by which the child acquires them. Our elders believed that traits contributing to a pleasant personality were bred in the bone. Now, however, we recognize clearly that they are learned reactions, which become automatic through many years of practice. The well-bred individual, having learned considerateness as a small child, will not blare his radio in the dead of night or honk his horn at the slightest delay in traffic.

Such inconsiderate actions, deplorably common, are merely adult counterparts of self-centered behavior patterns begun in the nursery. Unless very early in the life of the individual there are nurtured the spark of an inner compulsion based upon respect for the rights of others and the glimmering of insight into the legitimate needs of one's fellow man, there can be no genuine motive in adult life for cooperation and considerateness. Since children tend to reflect the unspoken attitudes of their elders, this learning can be assured only through courteous treatment which respects the growing child as an individual. Moreover, the child must have a basic sense of security if he is to learn to share and to respect genuinely the feelings

of others. The real tragedy of privation in early life is that the child tends to develop a pattern of aggressive behavior.

It is almost as difficult for an individual to find a substitute for an undesirable social inheritance as to make up for some lack in his biological heredity. In general, ill-bred individuals cannot recognize the need for a change. They see only the material rewards of their aggressive, selfish behavior and are incapable of appreciating the real cost to others upon which their small victories are based.

The solid core of human personality has its beginnings in the first few years of life. Now that many of our broad social institutions are concerned with the training of effective participants in competitive enterprise, the home, now as never before, stands out as the last refuge in which the individual who would be well-bred can get his training. And in a social order as intricate and complex as ours, the need for well-bred children and men and women is greater than ever.

HEALTH PHYSICS

In 1942, man succeeded in operating the first man-made, chain-reacting atomic machine, called a pile or reactor. A pile consists of graphite blocks and uranium slugs arranged in such a manner that energy in the form of neutrons, alpha, beta, gamma, recoil atoms, neutrinos, and heat is given off under controlled conditions. All piles produce penetrating radiations which would be very harmful to man if not handled with extreme care. Dr. Karl Z. Morgan, Director, Health Physics Division, Oak Ridge National Laboratory, discusses the protective devices necessary to prevent radiation damage, in *National Safety News* for April 1950.

Due largely to the existence of strong health physics organizations, no radiation damage has been suffered by anyone at the Atomic Energy Commission plants at Hanford, Washington, Argonne National Laboratory in Chicago, or at Oak Ridge National Laboratory in Tennessee. About 500 persons in the United States are devoting full time to study of radiation problems and methods of reducing radiation exposure to a minimum. They are conducting research and training programs for university, military, industrial, and public health service organizations.

The plants of the Atomic Energy Commission have set safety standards and developed methods of determining whether or not radiation protection is adequate. These are being applied satisfactorily in universities, hospitals, and laboratories.

Most institutions using radioactive materials require persons entering radiation areas to wear film badges and/or pocket meters. The meters are read at the close of each shift, and cases of appreciable radiation exposure are investigated immediately. Careful records are kept of accumulated external radiation exposures to X, gamma, beta, and neutrons for the protection of workers. Urinalyses are made of persons working with certain of the radioisotopes to determine whether these are being accumulated in the body. At regular intervals, health physicists survey every working area with a radiation hazard to determine the safe working time.

Special protective clothing must be provided for operations in which body contamination is possible. After completing such work, an operator uses a hand and foot counter to check for contamination. A GM tube probe is used to check clothing. Often special masks must be worn when entering "hot" cells, repairing contaminated hoods, et cetera. All protective clothing must be washed at the laboratory. After cleansing, it must be checked to make sure that contamination has been reduced to a safe level.

All the air and water discharged from a plant working with radioisotopes must be checked constantly to make certain that the contamination beyond the laboratory does not exceed safe limits.

Many hospitals, research and industrial laboratories all over the United States are using radioactive materials from Oak Ridge and many universities are producing their own isotopes. As a result radiation problems extend far beyond AEC operations. It is, therefore, the responsibility of public health and safety groups to ascertain that appropriate protection measures are enforced.

Where only three or four men are working

with radioisotopes, it will not, in general, be necessary to employ the full-time services of a health physicist. However, one competent person must be placed in charge of radiation protection. Proper instruments and radiation protection devices must be made available and used properly. Only if these precautions are taken can this new industry continue to be one of the safest in the country.

Civil Defense Planning

The National Security Resources Board is responsible for general leadership to civil defense planning groups. The Resources Board works through appropriate federal, state, and governmental agencies. Activities are closely coordinated with the programs of recognized professional organizations.

All past experience indicates that careful civil defense planning is essential to assure the best possible use of human and physical resources in the event of another war.

During the past few months the National Security Resources Board has recommended to the Governors that the state health officer be designated as the person officially responsible for statewide health aspects of civil defense. Almost every state has designated a civil defense representative responsible for stimulation and coordination of planning in the particular state. Inventories of professional health personnel, including nurses, have been made. The U. S. Public Health Service has prepared a preliminary statement of nursing needs of the civilian population. Courses are being planned for nurses in health programs associated with civil defense in coordination with the Atomic Energy Commission and the U. S. Public Health Service. Three cities—Washington, D. C., Seattle, and Chicago—are undergoing interim plan exercises which will serve as guides to other communities in their planning.

Nurses will be called upon to participate in civil defense planning in many ways. Since it is estimated that many millions of the civilian population will be required to help give first aid and nursing care during an emergency, one of the most important activities will be the training and supervising of nurses aides.

It is the responsibility of every nurse to familiarize herself with the plans of her own local and state groups working for civil defense and to be prepared to offer her services to them.

New Books
And Other Publications

CANCER NURSING

Margaret Knapp. Joint project of National Cancer Institute, U. S. Public Health Service; and New York State Department of Health. Write to State Health Department about availability. May also be purchased from Health Publications Institute, 216 North Dawson Street, Raleigh, North Carolina. $1; discount on quantity orders. 1950. 88 p.

The first impression upon perusing this booklet is one of pleasure in its attractive cover, its clear print, good index, and the excellent arrangement of headings in three parts: (1) The Control of Cancer (2) Home Nursing Care (3) Appendices.

The opening paragraph refers to the fact that cancer control must be part and parcel of the activities of every nurse working in the community. One hopes that subsequent editions will enlarge upon this point in order to make the booklet more valuable for the many nurses in very small public health nursing agencies, often without access to continuous staff education programs.

Miss Knapp writes clearly of the two-sided need for stimulating interest in the cancer problem among professional and lay people, at the same time working towards the development of resources for diagnosis and early treatment with unfailing persistence. We all know how discouraging it is to public health nurses and patients to recognize a problem and see themselves stymied for lack of facilities.

This reviewer was glad to notice a reference to the fact that the creation of fear can be a deterrent rather than an activator in relation to cancer control. Several very well drawn charts dramatically illustrate the fact that public health problems in the United States have shifted considerbly during the first half of this century. Cancer prevention is treated in a very concise paragraph which should be read in relation to a later one on carcinogens used in laboratories, hospitals, and industry.

The chapters on causes of cancer and cancer control are amazingly complete within the compass of the brief pages that could be devoted to them. It is assumed that a later edition will refer to the newly developing tool for case finding of abnormalities: the multiphasic examination of large groups of people. Reference to results of periodic health examinations, for instance, those reported by Dr. Catherine MacFarlane and the Peckham Health Center in London, England, would fortify public health nurses when trying to meet skepticism about the feasibility of physical examinations for large numbers of people.

Part II, Home Care of the Cancer Patient, contains helpful suggestions for the nursing care and instruction of the patient and his family. The need for understanding mental hygiene principles is implied repeatedly One hopes that this section will be enlarged in future editions. The author's considerateness for the patient as a person shines through the pages of this chapter. This chapter can be and should be fortified.

The chapter on patients under radiation therapy will be helpful to nurses who have not had a previous opportunity to learn to understand this type of therapy. Explanations about the use of x-ray and radium are clear and nurses will find the chapter dealing with reactions valuable as they prepare to talk to patients and answer their questions.

Several simple suggestions are offered for helping the patient, on a physical level, live through the difficult time of being under treatment for a serious illness. This section perhaps should be augmented by a brief explanation of the effect of x-ray on the action of sweat and sebaceous glands and on the suppression of secretions. The sections on specific nursing procedures have excellent photographs. Nurses will be especially pleased with the pictures that show how patients can learn to take care of their own special feedings and treatments. The pic-

tures on breast palpation are good visual aid material. The section on the female generative system does not mention fistulae between bladder and vagina or vagina and rectum, et cetera. These distressing complications, as well as evisceration, are less frequent today than they were, yet nurses run across them now and then and they should be fortified for the time when they may meet them.

The chapter on care of the advanced cancer patient is well written. Again one is impressed with the conciseness of the material presented. The appendix on common sites and types of cancer is exceedingly well arranged. One wonders whether it might not make this appendix still more helpful if in another edition a statement were added about currently used methods of treatment, for example, is one type of cancer more frequently treated by irradiation or by surgery? Do the extent of the lesion and the type of illness determine treatment? The last appendix is devoted to a discussion of special diets and gives practical, up-to-date suggestions for meeting specific needs. The bibliography will help nurses find additional material on medical and nursing subjects. It does not give any references on the social and mental hygiene aspects of the disease.

In summary, the booklet represents a job well done. It should prove useful as an introductory reference to nurses everywhere, not only to public health nurses.

—FRANZISKA GLIENKE, *R.N., Director, Visiting Nurse Association, Syracuse, New York.*

THE SOCIOLOGY OF THE PATIENT

Earl Lomon Koos, New York, McGraw-Hill Book Company, 1950. 264 p. $3.00.

This textbook in sociology prepared especially for nurses should help the beginning student gain a better understanding of the patient as a person who lives within, and is profoundly affected by, a specific social context.

The book is divided into three sections: Part One discusses the individual patient, Part Two the patient and his groups, Part Three the patient's activities and his problems. Part One, which consists of two rather brief chapters, introduces the patient as a person having a distinctive personality which the author defines as "that pattern of life which consists of the organized sums of the individual's attitudes and habits." There is a brief discussion of culture and of original nature, maturation, and socialization as factors in developing the life pattern of the individual. In this section the student is given a hurried glance at a number of fundamental concepts and ideas.

In the second section of the book two chapters are given to the patient as a member of a family and two more chapters discuss other groups in which the individual has membership. Play groups, school groups, neighborhoods, churches, community organizations, religious, national, and racial groupings are among those listed as significant in determining the individual's behavior. These groups are described as providing "an arena in which the personality performs at the same time that the groups help to develop the personality."

Part Three, which comprises the major portion of the book, treats of a number of activities and problems which affect the patient's beliefs, attitudes, and general behavior. Chapters are given to problems of getting a living, physical and mental health, and the use of leisure time. Other chapters deal with the handling of these problems with the help of various social and community agencies and through the patient's own understanding and adjustment.

The book concludes with a glossary, a list of supplementary projects, an outline for studying the patient and his family, a reading list, a list of visual aids, and an index.

This is a good book but it has several weaknesses which could easily be corrected in a later edition. The first two chapters are much too sketchy. A large number of concepts and ideas are presented without sufficient elaboration to make them intelligible to a beginning student. There is a great deal of waste space in the book. There is a preface, an editor's foreword, a full double page which contains one paragraph labeled To the Student, a list of questions at the end of each chapter, a full double page given to a one-paragraph summary at the end of each section, and another note to the student at the end. If

these two little messages to the student were put in the preface, the questions and references at the end of the chapters incorporated in the Projects, and the summary paragraphs either omitted or put at the end of the sections without being set off on full double pages, the author would have space to add at least twenty pages to his first section and thereby make a good book into an excellent one.

—Ina Corinne Brown, *Professor of Anthropology, Scarritt College, Nashville, Tennessee.*

THE HANDICAPPED CHILD

Edith M. Stern and Elsa Castendyck. New York, A. A. Wyn, 1950. 177 p. $2.00.

This book should be essential reading for parents of every handicapped child. Designed especially for them, it keynotes the importance of mental health, how it can and should be developed in order that the child with a handicap may attain the greatest degree of success and happiness possible for him.

Basic in every chapter is the underlying fact that behind a physical handicap is a child, a personality, who needs satisfaction in feeling secure, loved, and successful to the same extent as a normal child. The parents' role in meeting these emotional needs through their own emotional health forms the core of the book's content.

The first chapter, entitled Your Handicapped Child and You, is praiseworthy and filled with common sense. In studying it any parent would be stimulated to analyze his own feelings and problems, at the same time gaining reassurance in the fact that his own are quite in common with those of other parents. The succeeding chapters deal with specific handicaps and the application of the principles of child rearing which will insure the best mental health.

Because so many people associated with handicapped children tend to overemphasize the physical aspects of the handicap to the neglect of the emotional aspects, this book will be an excellent tool in developing a better understanding of the total needs of the child and how to meet them. The material given is practical and realistic. It is presented in an interesting and readable form. For parents or for persons working with handicapped children it will serve as a resource for securing further material and information from the references given in the text.

—Hedwig B. Trauba, *Supervisor, Nursing Services, Division of Services for Crippled Children, Springfield, Illinois.*

CHILD WELFARE

Between One and Five. Richard M. Smith. Pamphlet distributed by John Hancock Mutual Life Insurance Company, Boston. 1950. Free.

Your Child's Leisure Time. Mildred Celia Letton, Bureau of Publications, Teachers College, Columbia University, New York 27. 1949. 52 p. 60c. One of the Parent-Teacher Series. The customary thorough job is done on the subject. The problems are stated clearly and the solutions worked out logically and practically. The harassed parent will find it of great help in opening new vistas of leisure time for herself, freed from the burden of a fretful child.

Sitting Pretty, A Manual for Baby Sitters. Distributed by the Indiana State Board of Health and the Indiana Department of Public Instruction. 1950. 47 p. The material for the manual was prepared by a committee of leaders in child training and guidance activities. It explores some of the problems encountered by baby sitters and outlines courses of action. Although designed primarily as a text for high school classes in baby sitting it contains much of value to parents. There are six major divisions: general principles; basic principles of child psychology, et cetera; how to entertain children; what stories are suitable for children of various ages, what songs; food information, and safety precautions. The idea for the book grew out of experiences with classes in baby sitting at a local high school, and the content of the manual is the result of many consultations with those students.

Research Relating to Children, an inventory of studies in progress, reported December 1, 1948-June 30, 1949, to the Clearinghouse for Research

in Child Life. Report prepared under the direction of Clara E. Councell. Write to Childrens Bureau, FSA, Washington 25, D. C., for copies. 1950. 418 p. In the foreword Katharine F. Lenroot, Chief, Childrens Bureau, states: "We believe that this report is a unique contribution towards coordination and planning of research relating to children. . . . There are important areas of study as yet unexplored. Moreover, the interest of investigators from many fields in various aspects of a single problem suggests the need of more cross fertilization, as well as an increasing use of the multi-disciplinary approach. . . ."

GENERAL

THE HUMAN HEART. N. S. Haseltine. National Heart Institute, Washington 25, D. C. 1950. 22 p. Single copy free; additional copies may be secured from Government Printing Office, Washington, D. C., at 15c each, discount on quantity orders. Reprint of a series of articles which presents information for the general public about the heart and the diseases affecting the heart and circulatory system.

COLOR PSYCHOLOGY AND COLOR THERAPY. Faber Birren. McGraw-Hill Book Company, New York, 1950. 284 p. $4.50. A factual study of the influence of color on human life, containing information about its biological, psychological, and visual aspects, slanted especially toward medical practitioners to stimulate them to let color serve its beneficial purpose.

HEALTH EDUCATION

HOME NURSING TEXTBOOK, AMERICAN RED CROSS. The Blakiston Company, Philadelphia 5, 1950. 6th revision. 235 p. Paper cover, 60c; cloth, $1.

MATERNITY CARE

THE PIERRE THE PELICAN PRE-NATAL SERIES. Loyd W. Rowland. Pamphlet published by the Louisiana Society for Mental Health, 816 Hibernia Building, New Orleans 12. 1950. $1; discount on quantity orders.

MENTAL HEALTH

PATIENTS IN MENTAL INSTITUTIONS 1947. Charles C. Limburg. National Institute of Mental Health. For sale by Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 1950. 113 p. 50c.

NURSING

NURSING CARE OF THE SURGICAL PATIENT. John Pettit West, Manelva Wylie Keller, Elizabeth Harmon. Macmillan Company, New York. 5th edition. 1950. 500 p. $4.00.

NEW HORIZONS IN NURSING. Structure Steering Committee. Macmillan Company, New York 11. 1950. 110 p. $1.50. The story of the work and plans of the Committee on Structure of the National Nursing Organizations.

PUBLIC RELATIONS

HOW TO TURN IDEAS INTO PICTURES, a simple method of illustrating publicity and educational materials. H. E. Kleinschmidt. National Publicity Council, 257 Fourth Avenue, New York 10. 1950. 30 p. $1. Now you too can make your own illustrations for your annual report, bulletin, or poster! You really can, take our word for it! Dr. Kleinschmidt shows how a few simple strokes of your pen, pencil, or what-have-you, can create a picture that tells *your* story. The principles presented will enable group workers, health educators, et cetera, to make their audiences actually *see* the ideas as they hear about them.

SOCIAL HYGIENE

The following books and pamphlets dealing with sex offenses, family life education, et cetera, may be obtained from the American Social Hygiene Association, 1790 Broadway, New York 19:

LAWS DEALING WITH PROSTITUTION AND OTHER SEX OFFENSES. Johnson, Gould and Dickerson. 1947 revision. 600 p. $6. 1946 supplement separately $2.

LAWS AND REGULATIONS RELATING TO VENEREAL DISEASES. Johnson and Gould. 1947 revision, 700 p. $6. 1946 supplement separately $2.50.

THE SEXUAL PSYCHOPATH—A CIVIC-SOCIAL RESPONSIBILITY. Paul W. Tappan. ASHA Pub. A-791. 15c. Discussion of definitions, with comments on existing and needed legislation and treatment resources.

WOMEN SEX OFFENDERS IN NEW YORK COURTS. Bascom Johnson. Pub. A-772. 10c.

A PSYCHIATRIST LOOKS AT SEX OFFENSES. Philip Piker. Pub. A-702. 10c.

SEXUAL BEHAVIOR—HOW SHALL WE DEFINE AND MOTIVATE WHAT IS ACCEPTABLE? Papers and notes from panel discussion at 37th Annual Meeting of ASHA. Pub. A-796. 25c.

THE COMMON GROUND IN FAMILY LIFE EDUCATION. Symposium on points of agreement and emphases among the three major religious faiths, presented at 37th Annual Meeting of ASHA. Pub. A-798. 20c.

BEHAVIOR IN COURTSHIP. Jacques Bacal and Louise Sloane. Pub. A-787. 5c; discount on quantity orders.

FROM NOPHN HEADQUARTERS

ABOUT PEOPLE YOU KNOW

The School of Nursing at Seton Hall University announces the appointment of *Eleanor W. Mumford* as assistant professor of nursing, in charge of the public health nursing program; *Rhoda Cobin,* as instructor and field coordinator in public health nursing; and *Ruth T. McGrorey* as assistant professor of nursing. *Miss Mumford* has lately been director, Division of Public Health Nursing, North Dakota Department of Health. She has been an instructor of public health nursing at Teachers College, Columbia University, at the University of Minnesota, and at the University of California, Los Angeles. Before going to North Dakota, Miss Mumford was director of the Family Nursing Service of St. Paul, Minnesota, an assistant director of NOPHN, and consultant with the National Society for the Prevention of Blindness. *Miss Cobin* has been public health nursing instructor at the Joseph Lawrence School of Nursing in New London, Connecticut, public health coordinator at Lenox Hill Hospital in New York, and for the past two years public health staff nurse in the Brooklyn Regional Office, VA. *Miss McGrory* has been assistant editor of *The American Journal of Nursing* for the past year.

Grace Frauens, formerly director of the Visiting Nurse Association, Kansas City, Missouri, has been appointed director of the public health nursing program at the School of Nursing, Duquesne University. *Blanche L. George* who has been acting director is now director of programs in public health nursing, Department of Nursing Education, New York University. *Lucy C. Perry* has been appointed assistant professor in public health nursing at Indiana University where she previously has been an instructor. *Alberta B. Wilson,* assistant professor of public health nursing, University of Minnesota, has accepted the position of chief, Bureau of Public Health Nursing, Department of Public Health, Pittsburgh. Before going to Minnesota, Miss Wilson was an assistant director of NOPHN. Previously she was director of the Division of Public Health Nursing, Delaware State Board of Health. At Pittsburgh Miss Wilson is succeeding *Janice E. Mickey* who has joined the staff of the School of Public Health, University of Pittsburgh, as associate professor.

Teachers College, Columbia University, announces the following appointments: *Frances M. Frazier,* lately associate in public health nursing in the Department of Public Health Practice, Harvard School of Public Health, as instructor in nursing education; *Louise C. Smith* as instructor in nursing education. Miss Smith served with UNRRA in Greece and the Near East and has been assistant educational director with the VNS of Philadelphia for the last two and a half years. Also, Mrs. Lydia E. W. Hall, as instructor in nursing education. Mrs. Hall has lately been on the staff of the New York Heart Association.

Margaret L. Varley has succeeded Miss Frazier as associate in public health nursing at Harvard. Miss Varley was a nursing consultant with UNRRA during World War II and was awarded a Distinguished Service Citation from the Greek Red Cross. After the war she was nursing adviser for the Rockefeller Foundation, Middle East Division.

The Cortland County Health Department in New York announces that *Margaret Wol-*

cott has resigned as director of nurses to become school nurse in Corning, New York. *Mary Ann Griffin* has also resigned from the department to accept a position in Chenango County in the same state. . . . Saint Louis University has named *Alice Mary O'Leary* as instructor and coordinator of the public health nursing program in basic nursing in the School of Nursing. Miss O'Leary was previously supervisor of public health nursing for the Atomic Energy Commission . . . . *Helen Krueger* has retired as school nurse with the Everett (Mass.) Board of Health after thirty-two years of service . . . . *Lucille Notter,* assistant director of the Visiting Nurse Service of New York in charge of educational programs, has been appointed director of the joint educational program of the VNSNY and of the Visiting Nurse Association of Brooklyn. . . . The U. S. Public Health Service has appointed *Elsie T. Berdan* as chief of the Nursing Branch, Division of Hospitals, replacing *M. Constance Long,* who has resigned to be married. Miss Berdan has been serving as associate chief of the Nursing Branch.

STAFF CHANGES

Kathryn A. Robeson who has been part-time secretary to the ANA-NOPHN Committee on Nursing in Medical Care Plans during 1950 has resigned to accept a consultant nursing position in the State Department of Health in Michigan. Miss Robeson was also on the staff of the Visiting Nurse Service of New York and at the time of her resignation was assistant director in administration.

100% STAFF MEMBERSHIP

We are happy to report that four more public health nursing agencies have achieved 100% NOPHN membership among the nursing staff since our last list appeared. Congratulations to all!

ILLINOIS
Vandalia—Fayette County Rural and Tuberculosis Nursing

IOWA
Des Moines—Public Health Nursing Association

MASSACHUSETTS
Duxbury—Duxbury Nurse Association

MICHIGAN
Allegan—Allegan County Health Department

NOPHN FIELD SCHEDULE—AUGUST

Staff Member	*Place*
Elizabeth C. Stobo	Elizabeth, N. J.
Lois Olmsted	Houston, Texas
Anita Searl	Greensboro, N. C.
Jane R. Sloan	Washington, D. C.

July field trips not previously reported: M. Olwen Davies, Ann Arbor, Michigan; Marion P. Kerr, Sioux City, Iowa; Lois Olmsted, Key West, Miami, and Pensacola, Florida; Jane R. Sloan, Sacramento, California. Jean South visited Portland, Oregon, and Seattle, Washington, in June.

MOBILIZING HEALTH RESOURCES

A Health Resources Office has been established in the National Security Resources Board, succeeding the Health Resources Division of the board's Civil Defense Office. The new Office, with increased responsibilities, is charged with the vital task of planning for the use of the nation's health resources in wartime. Dr. Norvin C. Kiefer, who directed the earlier division, is director.

The Civil Defense Office remains responsible for all planning for defense against atomic, biological, and chemical warfare. The Health Resources Office will deal with such problems as mobilization of health personnel, environmental sanitation, utilization of health facilities, provision of equipment and supplies, recommendations for maintaining essential teaching and research in health fields.

The new Office will also work closely with the Health Resources Advisory Committee. This committee was formed recently to assist and advise the National Security Resources Board on health problems involved in national mobilization and in the event of atomic war. Chairman of the committee is Howard A. Rusk, M.D., chairman of the Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center.

NEWS AND VIEWS

PROGRAMS IN TUBERCULOSIS NURSING

Programs in tuberculosis nursing on the graduate level are being offered by the Department of Public Health Nursing of the State University Medical Center at Syracuse and the Syracuse University Department of Nursing Education. The programs, which are given in cooperation with the New York State Department of Health and Trudeau Sanatorium, are planned to meet the needs of graduate nurses in hospitals, clinics, public health agencies, and schools of nursing.

For students of public health nursing, two programs on tuberculosis nursing in the community are offered: a program of one calendar year leading to a M.S. degree and a semester of supplemental courses, acceptable toward a baccalaureate degree. Further information and application forms may be secured by writing Miss Ruth E. TeLinde, Director, Department of Public Health Nursing, Medical Center at Syracuse, 766 Irving Avenue, Syracuse 10, New York.

NATIONAL CONFERENCE ON CARDIOVASCULAR DISEASES

"The Report of the National Conference on Cardiovascular Diseases" may be secured from the American Heart Association, 1775 Broadway, New York 19, N. Y. This is a digest of the materials discussed at the conference held in Washington in January 1950. The conference was sponsored jointly by the American Heart Association and the National Heart Institute, USPHS. The report covers the highlights of the conference and reviews recent progress in the heart disease field as well as proposals for improved programs of research, prevention, treatment, management, and education. Single copies are free.

Proceedings of the First National Conference on Cardiovascular Diseases has just been published. This is the complete record of the conference with detailed section and committee reports. Marion W. Sheahan and Mary E. Parker were co-chairmen for the Committee on Nurse Education.

The Proceedings should prove valuable in inservice education for public health nursing groups. Copies may be ordered from the American Heart Association in New York, at $1.75 each.

APHA MEETING

The annual meeting of the American Public Health Association and meetings of thirty-two related organizations will be held in Kiel Auditorium, St. Louis, Missouri, October 30 to November 3.

More than 400 speakers and discussants will participate in the scientific programs which are being developed by thirteen sections. These sections include: food and nutrition, health officers, public health nursing, school health, and statistics.

The program will be published in the September issue of the *American Journal of Public Health*. Additional information may be obtained from Dr. Reginald M. Atwater, executive secretary, APHA, 1790 Broadway, New York 19.

THE NAVY WANTS NURSES

The surgeon general of the Navy has asked doctors, dentists, and nurses in the inactive U. S. Naval Reserve to volunteer immediately for extended active duty. Nurses holding the rank of lieutenant or below will be accepted. Application should be made to the chief of naval personnel, Navy Department, Washington 25, D.C.

However, any member of the corps on in-

active duty who has dependents under the age of eighteen regardless of legal custody will not be eligible for active duty. She should immediately notify the commandant of her home Naval District and the Bureau of Medicine and Surgery, Navy Department, Washington 25, D.C., of her current dependency status.

Qualified civilian nurses may apply for active duty in the Nurse Corps of the Naval Reserve. They will be commissioned in ranks up to and including lieutenant, depending upon age and professional experience.

Further information may be secured from any Office of Naval Officer Procurement.

INDUSTRIAL NURSES CONFERENCE

Industrial nurses representing the New England states and guests from New York and Pennsylvania attended the annual spring conference of the New England Industrial Nurses Association at Wentworth-By-The-Sea in New Hampshire June 23-25.

Among the guest speakers was Claude A. Putnam, president of the National Association of Manufacturers. He discussed "How the National Association of Manufacturers Feels toward Industrial Nursing Services in Small and Large Plants."

The association will hold its fall conference in Boston November 3-5. Reservations may be made by writing Miss Mary E. Rice, R.N., Chairman, Publicity Committee, NEINA, 76 Greenfield Street, Hartford, Conn.

NATIONAL ASSOCIATION FOR MENTAL HEALTH

Another merger of national organizations is under way. After a study of programs of the National Committee for Mental Hygiene, the National Mental Health Foundation, and the Psychiatric Foundation, plans have been made to merge the three into the National Association for Mental Health. Final action awaits the approval of the several memberships.

All three parent organizations have common goals and aims although their emphases have been different. It is expected that the National Association for Mental Health will allow for a greater scope of overall activity and in addition will go far in overcoming the public's confusion about the duplication of organization efforts and fund raising in the field of mental health.

PROGRAM IN MENTAL HEALTH

The School of Nursing Education of the Catholic University of America announces a program in mental health for selected public health nurses. The program is on a graduate level and is designed to develop the skill and understanding necessary for performance as a consultant in mental health in nursing services. A limited number of stipends are available under the National Mental Health Act.

The minimum length of the program covers a period from October 1950 through the following summer session plus the first semester of a second year. For further information and application forms, write to the Registrar, Catholic University of America, Washington 17, D. C.

CEREBRAL PALSY INSTITUTE

A two-week institute in cerebral palsy has been announced by The Coordinating Council for Cerebral Palsy in New York City, Inc. The institute, which will start on November 6th, is designed for qualified physicians, nurses, physical, occupational, and speech therapists, social service and guidance workers, and teachers. The program will include lectures, clinical demonstrations, and seminars.

Further information may be obtained by writing Miss Marguerite Abbott, executive director of the council, 270 Park Avenue, New York 17.

THIRD MENTAL HEALTH ASSEMBLY

Mrs. Helen G. Bowditch, instructor in nursing at the University of Minnesota School of Nursing, attended the third annual meeting of the World Federation for Mental Health, held in Paris, August 31 to September 7, as NOPHN's delegate. (See PHN, April 1950, p. 246.)

Mrs. Bowditch has participated in activities relating to mental health in public health nursing. She attended the NOPHN conference on mental hygiene education for public health

nurses held in New York, November 1949; a conference of mental health consultants held in Pittsburgh during January 1950; and the conference of psychiatric and mental health educators held in Minnesota during April 1950 to discuss important factors in the education of these groups. She is a member of the Advisory Panel on Psychiatric Nursing to the Nursing Consultants of the National Institute of Mental Health.

Other persons attending the Mental Health Assembly as observers for NOPHN were Helen McKey, instructor in nursing at the University of Washington; Alice Brackett, assistant director of the Nursing Unit, Children's Bureau, FSA; and Elizabeth Brackett, nursing advisor at the Rockefeller Foundation in Paris.

SAFETY CONGRESS

The 38th National Safety Congress and Exposition will be held October 16-20 in Chicago. Details of program, et cetera, may be secured by writing R. L. Forney, National Safety Council, 425 N. Michigan Ave., Chicago 11.

CIVIL SERVICE EXAMINATIONS FOR PUBLIC HEALTH NURSE

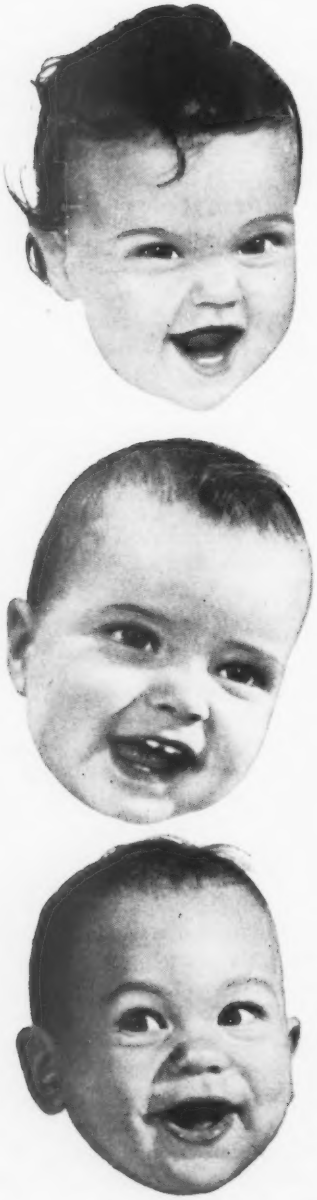
The U. S. Civil Service has announced a new examination for Public Health Nurse to fill positions paying $3,825 a year in the Bureau of Indian Affairs of the U. S. Department of the Interior. These positions are located principally on reservations west of the Mississippi River and in Alaska. Because of housing facilities, applications will be accepted only from female nurses.

No written test is required. To qualify, applicants must meet the following requirements: (1) completion of either a full 3-year resident course in an approved school of nursing or a full 2-year course in an approved school plus 1 year of appropriate nursing experience or pertinent education (2) successful completion of at least 30 semester hours in a program of study in public health nursing meeting the requirements of the NOPHN and approved by the National Nursing Accrediting Service; this study may be included in or supplementary to the education described in (1) above (3) at least 1 year of experience in a public health nursing program in a rural or urban health agency (4) current registration as a graduate professional nurse in a state or territory of the United States or in the District of Columbia, at the time of appointment.

Because of the arduous duties involved, applicants must not have passed their 40th birthday on the date of filing application. This age limit does not apply to persons entitled to veterans' preference.

Although applications will be *accepted until further notice,* persons who wish to receive early consideration should file their applications immediately with the U. S. Civil Service Commission, Washington 25, D.C.

Further information and application forms may be obtained from most first- and second-class post offices, civil service regional offices, or from the Commission in Washington.



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